REPORT

FOCUS ON KEY POPULATIONS IN NATIONAL HIV STRATEGIC PLANS IN THE AFRICAN REGION

SEPTEMBER 2018

World Health Organization
REGIONAL OFFICE FOR Africa

Focus on key populations in national HIV strategic plans in the WHO African Region, September 2018

WHO/AF/CDS/HIV/02, 2018

Suggested citation. Report on key populations in African HIV/AIDS : national strategic plans, July 2018. Brazzaville: WHO Regional Office for Africa; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Photo cover ©Nicolas Raymond

Design and layout by L'IV Com Sàrl

Printed in the WHO Regional Office for Africa, Brazzaville, Congo

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CONTENTS

ABBREVIATIONS AND ACRONYMS

ART	antiretroviral therapy
BCC	behaviour change communication
CBO	community-based organization
CSO	civil society organization
CSW	commercial sex workers
DIC	drop-in centre
FSW	female sex worker
HTS	HIV testing services
IDU	injection drug user
KAP	key affected population
KP	key population
MARP	most-at-risk population
MSM	men who have sex with men
NSP	national strategic plan (to avoid confusion with "national strategic plan", "needle and syringe programme" is always written in full)
OST	opioid substitution therapy
OVC	orphans and vulnerable children
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
PWUD	people who use drugs
SDC	serodiscordant couple
STI	sexually transmitted infections
SW	sex workers
TB	tuberculosis
TG	transgender
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

The World Health Organization (WHO) defines key populations as populations who are at higher risk for HIV irrespective of the epidemic type or local context and who face social and legal challenges that increase their vulnerability. They include sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prison and other closed settings. In addition to experiencing elevated HIV risk and burden and facing legal and social issues, these populations historically have not received adequate priority in the response to the HIV epidemic, especially in countries with generalized HIV epidemics.

The five key populations:
- men who have sex with men
- people in prisons and other closed settings
- people who inject drugs
- sex workers
- transgender people.

National strategic plans (NSPs) play a vital role in fostering the understanding of and guiding the collective response to 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 that these plans consider key populations. In particular, we assessed:

- how key populations and their HIV risk are represented in NSPs;
- whether the plans include epidemiologic information on the HIV epidemic among key populations;
- whether these plans include the WHO-recommended package of interventions for key populations; and
- the extent of involvement envisioned for key population communities in HIV interventions addressing these populations.

Based on the findings, we recommend improvements regarding the inclusion of key populations in the NSPs.

FINDINGS

1. How are key populations and their related HIV risk presented?

National strategic plans could be located for 45 of the 47 countries. All of these plans mention key populations, albeit with some differences as to who is considered a key population. All 45 national strategic plans include sex workers (who are mostly understood to be female), 42 include prisoners, 41 include men who have sex with men, and 38 include people who inject drugs, while only 10 mention transgender persons. Overlap among key populations is rarely acknowledged, and there is little specific attention to young and adolescent members of key populations.

Elements of WHO's definition of key populations are usually integrated into national strategic plans, although terms other than "key populations" are often used. Most national strategic plans define key populations as marginalized populations, most-at-risk populations, priority populations and/or vulnerable groups. Other populations disproportionately affected by the HIV epidemic are often included under the rubric of key populations, such as migrants, truck drivers and fishermen. Including these additional groups obscures the special social and legal circumstances of the key populations defined by WHO. The fact that societal pressures or legal circumstances make key populations especially vulnerable to HIV exposure is not always acknowledged.

2. Do the plans include epidemiological information on key populations?

Mention of data on key populations, including prevalence, attributable risk, population size estimates and structural risk factors, is inconsistent in NSPs. Epidemiological information about key populations tends to focus on HIV prevalence: About two thirds of the plans report HIV prevalence among sex workers, and half report prevalence among men who have sex with men. Prevalence among the other key populations is less often mentioned; two fifths of national strategic plans report prevalence among people in prison, and one third report prevalence among people who inject drugs. Only one plan reports prevalence among transgender persons.

Information on HIV incidence among key populations is missing from most national strategic plans, with the exception of some estimates for sex workers and men who have sex with men. Individual risk factors for HIV infection are reported less frequently than prevalence, but more frequently than incidence.

3. Do national strategic plans include the WHO-recommended package of interventions?

The comprehensive package of interventions recommended in the WHO *Consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations* (2016) includes both health and structural interventions. Compared with the WHO comprehensive package and recommendations, there are significant gaps in intended or planned HIV services described in many national strategic plans.

Compared with the WHO comprehensive package, the NSPs have significant gaps.

Mentions of the WHO recommendations in national strategic plans refer mainly to health-related interventions. The structural interventions, or critical enablers – activities to overcome major barriers to service uptake, including social exclusion, marginalization, criminalization, and stigma – are only sporadically addressed. For instance, the adverse impact of the criminalization of sex work or homosexuality on HIV transmission risk is sometimes acknowledged, but few national strategic plans recommend review of laws and/or practices that criminalize these behaviours. Some, but not all, national strategic plans mention the need for (sensitization) training of health-care workers to address stigma and discrimination in the health sector.

HIV prevention and HIV testing are the health interventions most often cited for key populations. Innovative HIV testing modalities, such as lay-provider testing, assisted partner notification and self-testing are rarely mentioned, however, perhaps because many national strategic plans were developed before WHO issued recommendations endorsing these interventions. Few national strategic plans included pre-exposure prophylaxis (PrEP), likely for the same reason.

Some 17 national strategic plans mention harm reduction strategies for people who inject drugs. All but one of these 17 plan needle and syringe programmes. Just eight plan opioid substitution therapy programmes.

4. Do plans address the extent of community involvement?

Over half of plans acknowledge the importance of involving communities of key populations, especially communities of sex workers and men who have sex with men. Rarely mentioned in this respect are transgender people, people in prisons and other closed settings or people who inject drugs. When acknowledged, national strategic plans attribute various roles to communities of key populations, including facilitating access to and improving health services, involvement in framing the national response to HIV, monitoring policies, and advocacy and accountability. A few national strategic plans mention the importance of the empowerment of key populations in addressing the HIV epidemic.

DISCUSSION

All national strategic plans mention at least one key population, and the great majority include some interventions for key populations. Strategies to address HIV in sex workers are included in all but two plans. The majority also include interventions for men who have sex with men, people who inject drugs and prisoners. Some plans show interest in innovative strategies such as PrEP, self-testing and assisted partner notification for key populations. There is opportunity for these relatively new WHO recommendations to be included as planned interventions in future strategic plans.

All but two NSPs include interventions for sex workers. Most include interventions for men who have sex with men, people who inject drugs and prisoners.

There are gaps in programming of HIV services as measured against WHO recommendations. The gaps are particularly evident for transgender people, people who inject drugs and prisoners. Overall, plans pay little specific attention to young members of key populations.

Included interventions for key populations tend to focus on HIV prevention and HIV testing services. Descriptions of prevention services lack detail or specificity regarding how to tailor combinations of interventions to address the particular needs of individuals.

Gaps in the description of services are particularly evident for transgender people, people who inject drugs, prisoners and young members of all key populations.

Seventeen countries refer to harm reduction, 16 of them planning harm reduction through needle and syringe programmes and eight planning opioid substitution therapy. In some countries where there is no evidence of injecting drug use, lack of mention may be appropriate. However, while harm reduction is highly effective in preventing HIV transmission in people who inject drugs, these interventions are not consistently included in the strategic plans of countries in the African Region that have evidence of injecting drug use.

Aside from prevention and testing, plans pay limited attention to providing treatment services friendly to key populations or to linking people who test negative to further prevention services (condom programming, PrEP, harm reduction) and linking people who test positive to treatment.

Few national strategic plans provide comprehensive data on HIV prevalence, incidence or population size for all key population groups. In some cases lack of data is identified as a problem. In other cases available data are overlooked or omitted.

Some 42 national strategic plans mention people in prisons and other closed settings, and 27 present specific plans to extend services to this population to prevent sexual transmission of HIV. Overall, few countries pay attention to continuity of care for prisoners on treatment – an important omission because interruption of treatment when people move between the community and prisons as well as within prisons is a major concern.

LIMITATIONS OF THIS REVIEW

Some limitations are important to consider when interpreting the findings presented in this review.

The planning periods of the reviewed NSPs vary. Thus, some were no longer current at the time of writing (Algeria, Angola, Cape Verde, Comoros and Mauritania), and others were coming to an end.

Assessing whether recommendations from the WHO consolidated guidelines for key populations are included in national strategic plans is not always straightforward. Sometimes the information is not explicitly presented, and in other cases lack of detail prevents clear judgments. Also, it is not always clear which intervention is proposed for which population.

National strategic plans do not necessarily reflect the HIV programming being implemented in the country. There might be more programming conducted than is mentioned. At the same time, some programming articulated in the national strategic plan may not be implemented in the period of the plan.

Also, WHO recommended some interventions, such as PrEP and HIV self-testing, after some of the national strategic plans were developed. This makes this analysis of included interventions problematic. Further, the WHO comprehensive package may not be relevant in all settings; often a standard package of services based on evidence, utilizing WHO guidance and developed in consultation with all partners in country, will be more appropriate and feasible.

RECOMMENDATIONS

Review of these 45 national strategic plans provides a snapshot of how key populations are considered in the African Region. While there are some limitations to the methodology and results, as described above, we can deduce some important messages from this exercise:

Coverage

- Advocacy at global and national levels for **inclusion of key populations** in the national HIV responses needs to continue. The findings of this review can be disseminated to help support that inclusion.

- Countries developing **new strategic plans** need to include the key populations. There may be other populations disproportionately affected by HIV and so deserving attention. Still, the five key populations defined by WHO and UN partners deserve particular and specific attention. These populations face structural barriers to services that compound their risk exposure – barriers such as laws that criminalize their behaviour, stigma, discrimination and violence.

- In order to improve global monitoring of the HIV epidemic and response, it is important that countries consistently follow and use the WHO's terminology for key populations.

- Plans need to specifically consider **young people in key populations** and their particular needs.
- National plans should recognize and accommodate **diversity within key populations**, particularly among sex workers and transgender people.

Interventions

- National strategic plans should incorporate the **defined and evidence-based package of interventions** for key populations, including health sector interventions that foster an enabling environment tailored to the national context.
- **Involving key population communities** in service delivery will increase the reach and effectiveness of prevention, testing, treatment and care. Lay providers can be members of key populations who take on important aspects of service delivery and thus increase accessibility. National programmes can establish the roles of lay providers in serving key populations.
- **Access and adherence to treatment** can be particular problems for members of key populations. Strategic plans should specify how programmes will address these issues, which include treatment interruption due to incarceration or migration.
- Efforts to strengthen **strategic information systems** should explicitly address strategic information for key populations and schedule periodic national assessments of the implementation of key population interventions.

Structural barriers

In addition to health interventions, national strategic plans need to review structural barriers relevant to the country and include the critical enablers to address them. WHO can support countries' activities to reduce stigma and discrimination in the health sector, mainly through training of health-care workers. Other UN agencies such as UNDP and UNAIDS can support national reviews of laws and regulations that impede an effective public health response to HIV.

ACKNOWLEDGEMENTS

Theo Sandfort (Columbia University) and Keletso Makofane (Harvard University) prepared this report. It was commissioned by WHO and developed in collaboration with Annette Verster and Virginia Macdonald, under the responsibility of Rachel Baggaley, in the WHO HIV Department. James Buchanan, Grace Herndon and Samantha Khandakji coded the NSPs with support from Stephanie Serafino and supervised by Theo Sandfort. Hugues Lago, Frank Lule and Buhle Ncube (WHO Regional Office for Africa) and George Ayala and Mohan Sundararaj (MPACT – Global Action for Gay Men's Health and Rights) helped to interpret the findings and reviewed earlier versions of the document. Jura Editorial Services edited the final version.

INTRODUCTION

BACKGROUND AND AIMS

HIV/AIDS national strategic plans (NSPs) help to guide and coordinate the work of multiple stakeholders in national responses to HIV. They outline the broad multi-sectoral strategy, highlighting the roles played by different government and nongovernmental agencies. Because NSPs aim to articulate the full set of interventions needed to control the HIV epidemic in a country, the NSP can be used to guide the allocation of domestic and donor resources across different programme areas. Internationally, NSPs have been used to coordinate donor funding and technical assistance.

While there is wide variation in the structure and content of NSPs across African countries, many include the following components: A *situation analysis*, which synthesises evidence on the epidemiology of HIV/AIDS; a *response analysis*, which reviews and appraises past intervention strategies; a *strategic plan*, which outlines proposed intervention strategies based on the first two components; and a *resource mobilization* component, which quantifies the resources needed to implement the strategic plan and outlines a strategy to mobilize those resources.[1,2]

Because of their central role in fostering the understanding of and shaping the collective response to HIV epidemics, it is crucial that NSPs address key populations. The World Health Organization (WHO) defines key populations as populations that are at higher risk for HIV irrespective of the epidemic type or local context and that face social and legal challenges that increase their vulnerability. WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*[3] focuses on five populations:

Because of their central role in shaping the collective response to HIV epidemics, it is important that NSPs address key populations.

- men who have sex with men,
- people who inject drugs,
- people in prisons and other closed settings,
- sex workers and
- transgender people.

In addition to experiencing elevated HIV risk and burden and facing legal and social issues, these populations historically have been relatively neglected in the global response to the HIV epidemic.

WHO commissioned a review of the NSPs of countries in the WHO African Region with the overall aim of identifying strengths, gaps and weaknesses in the way that NSPs address key populations. This review will inform recommendations for improving the consideration of key populations in NSPs.

For this review we analysed (1) how key populations and their HIV risk are represented in NSPs; (2) whether NSPs include epidemiologic information on the HIV epidemic among key populations; (3) whether NSPs address the recommendations made in the WHO consolidated guidelines for key populations; and (4) the extent to which NSPs address the involvement of key population communities.

While NSPs are a rich source of information on how key populations are understood and integrated into national planning processes, they do not necessarily reflect funded and implemented programming: Some intervention strategies described in an NSP may not be implemented during the implementation period. At the same time, some responsive and innovative interventions conducted by local key population-led organizations, while relevant to the national HIV response, may not be captured in the NSP. The methods and limitations sections below discuss the limitations of NSPs and of the methods employed to conduct this review. In the chapters that follow, we describe how NSPs address each of the five key populations.

NSPs do not necessarily reflect funded and implemented programming.

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[1] Guide to the strategic planning process for a national response to HIV/AIDS – introduction. Geneva: Joint United Nations Programme on HIV/AIDS; 1998 (http://data.unaids.org/publications/IRC-pub05/jc441-stratplan-intro_en.pdf, accessed 31 October 2017).

[2] Planning guide for the health sector response to HIV. Geneva: World Health Organization; 2011. (http://www.who.int/hiv/pub/guidelines/9789241502535/en/, accessed 1 May 2018).

[3] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2014; updated 2016 (http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/, accessed 31 October 2017).

METHODS

NSPs reviewed

In collaboration with WHO, we identified the most recent NSPs of the 47 countries supported by WHO's Regional Office for Africa (AFRO) (see List of national strategic plans at back of this publication). We were not able to locate the NSPs of Equatorial Guinea and Gabon. Some NSP documents were missing publication information such as the year of publication[1] or the publishing agency.[2] For some NSPs we were able to obtain only draft versions,[3] and some were shared with us in a format that was editable.[4] For these NSPs we cannot be certain that the version we analysed was the authorativie version of the document.

As Fig. 1 illustrates, the planning periods of the identified NSPs vary. Five were no longer current at the time of writing (Algeria, Angola, Cape Verde, Comoros and Mauritania), and others were coming to an end. The diversity in time frames should be considered when interpreting findings of this review.

Data abstraction and analysis

To address the aims of this review, we adopted two approaches to process the information: (a) information was abstracted from each NSP using a set of fixed categories; and (b) all NSPs were reviewed to assess whether they included the recommendations made in the WHO consolidated guidelines for key populations regarding both health sector interventions and critical enablers. For both strategies we located relevant information systematically in all NSPs by using, as search terms, the names of the various key populations and relevant constructs such as "prevalence", "HIV testing", "pre-exposure prophylaxis" ("PrEP"), "criminalization" and "community mobilization".

For the first approach we abstracted information from the NSPs about key populations in general and about each of the five WHO-defined key populations separately. We assigned the abstracted Information to five main categories of interest: (a) the way in which key populations are defined and represented in the NSPs; (b) epidemiologic information about the key populations; (c) planned prevention, treatment and monitoring activities for key populations; (d) planned activities to address stigma and legal issues relevant to the specific key populations; and (e) operational aspects, including costing and institutional involvement. Within each main category there were subcategories meant to ensure capture of the breadth of the available information in each category. Three people conducted the abstracting, coding and translation. The abstracted information was subsequently synthesised for this report.

The second approach consisted of reviewing whether the NSPs had adopted recommendations from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.[5] To do so, we adapted a checklist based on these guidelines, pilot-tested the checklist and then further adapted it. Panel 1 present the final checklist. Despite our efforts to arrive at unambiguous criteria, the criteria were not always easy to apply in practice. Some NSPs addressed "key populations" in general without clearly indicating which populations were meant or whether planned interventions applied equally to all included populations. Some NSPs referred to "specific groups" or "people affected by HIV" without specifying which populations were included. Finally, while some NSPs acknowledged the importance of enablers – "strategies, activities and approaches that aim to improve the accessibility, acceptability, uptake, equitable coverage, quality, effectiveness and efficiency of HIV interventions and services"[6] – they did not always specify concrete plans to implement them.

The primary focus in the review of the NSPs was HIV. We additionally reviewed more general information on sexual and reproductive health. We did not include tuberculosis and other communicable diseases usually associated with the response to HIV.

In this report any grouping of populations in the NSP that included men who have sex with men, people who inject drugs, or people in prisons and other closed settings, sex workers or transgender people was included in the analysis for *key populations*. In other words, unless otherwise stated, when we write "key populations", we mean any grouping of populations that appears in an NSP where that grouping includes at least one of the five WHO-defined key populations.

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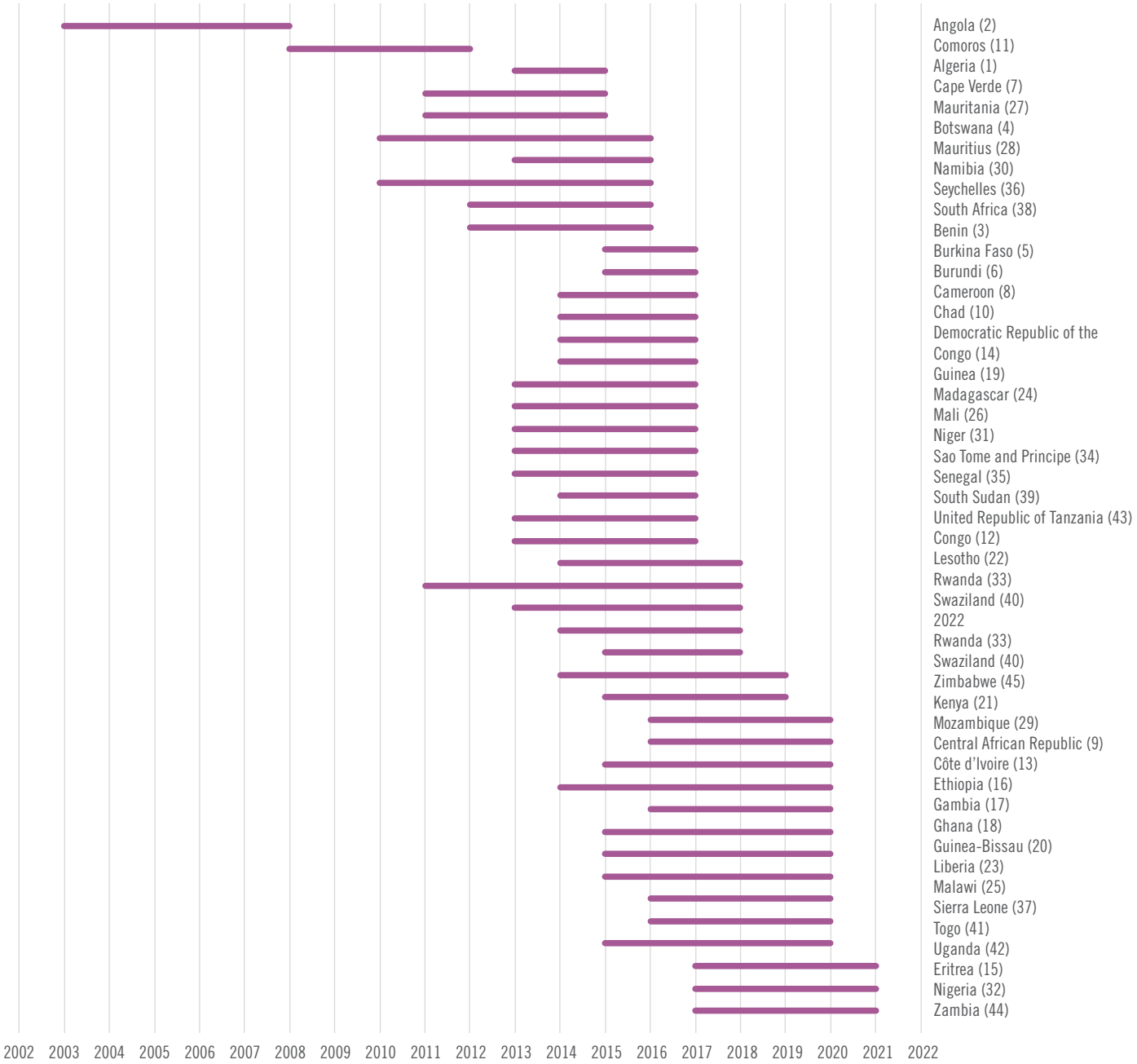
[1] Angola, Chad, Gambia, Guinea, Kenya, Madagascar, Mauritius, Nigeria, Rwanda, Senegal, Seychelles, Zambia.
[2] Angola, Lesotho.
[3] Angola, Central African Republic, Congo, Nigeria, Togo.
[4] Central African Republic, Chad, Côte d'Ivoire, Guinea.
[5] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2014; updated 2016 (http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/, accessed 31 October 2017)
[6] *Ibid.*

Fig. 1. Planning periods for HIV national strategic plans in the WHO African Region



Limitations of this report

The findings presented in this report are subject to some limitations. This review is a snapshot; national HIV programmes are continuously evolving. Some of the NSPs reviewed were already outdated at the time of writing, and it is likely that some plans were already being revised. Also, it proved challenging to obtain officially published NSPs. As a result, we included NSPs that were in draft versions. Even though NSPs are the primary source of guidance for national HIV responses, other documents, such as national health strategies, PEPFAR country operating plans and Global Fund funding applications, might productively be analysed to understand trends in HIV responses for key populations across sub-Saharan Africa.

This review is a snapshot; national HIV programmes are continuously evolving.

Assessing the integration of the WHO recommendations on key populations into national strategic plans was complicated by the fact that it was not always clear whether an NSP was recommending a given intervention for a given population. For instance, many NSPs mentioned "human rights protection" but rarely discussed it as a focus for interventions addressing the legal and social position of key populations. Similarly, access to post-exposure prophylaxis (PEP) was regularly mentioned and discussed in relation to accidents at work and women who have been raped. Key populations were rarely mentioned in relation to PEP, however. Finally, many NSPs pay attention to sexual violence, but they discuss it as sexual violence against women in general. Sexual violence that members of key populations encounter was less often considered. Where a particular intervention was not linked either to a specific key population or to key populations in general, we did not list it as a targeted intervention.

In contrast, we took a lenient approach to interventions explicitly linked to key populations. For instance, if an NSP recommended an intervention for key populations in general, we counted that as an intervention for each of the key populations included in the definition of key populations in that particular NSP. This might overestimate planned programming for key populations in national strategic plans. Because we identified relevant information in NSPs using key word searches and not by close, word-by-word reading, this document does not present a detailed analysis of any given NSP, but rather it presents an overall analysis of the contents of NSPs across the WHO African Region. This was the goal of the study.

If an NSP recommended an intervention for key populations in general, we counted that as an intervention for each of the key populations.

KEY POPULATIONS

"KEY POPULATIONS" AND RELATED TERMS

A majority of NSPs used the term "key populations" to describe a category of populations of special interest in the HIV epidemic. The exact meaning of this term – which populations it represents and what those populations have in common – varied within and across NSPs. Below we describe how "key populations" and related terms were defined and employed in NSPs. We pay particular attention to the five WHO-defined key populations.

NSPs use multiple terms to describe groups of populations. Examples are "marginalized populations", "most-at-risk populations", and "vulnerable groups". The NSP for Malawi, for instance, placed men who have sex with men and sex workers in the category "key populations", while it placed prisoners in the category "vulnerable populations".

Of the 45 NSPs reviewed, only eight included all five key populations as defined by WHO (Table 1). Those eight are Ghana, Kenya, Lesotho, Mauritius, Nigeria, Senegal, Sierra Leone and South Africa. The other NSPs included some smaller number of the WHO-defined key populations among their key populations. Sex workers appeared in all 45 NSPs, followed in decreasing order by people in prisons and other closed settings (42), men who have sex with men (41), people who inject drugs (38) and transgender people (10).

Selected examples of key populations identified in national strategic plans

Burkina Faso
The Burkina Faso NSP listed as priority populations men who have sex with men, youth, sex workers, people who inject drugs, prisoners, mobile populations, drivers, men in uniform, people living with HIV, and women of childbearing age.

Burundi
The Burundi NSP specified populations that should be targeted for the prevention of HIV transmission. These were men who have sex with men, steady couples in the general population, young people under the age of 25, sex workers and their clients, inmates, injecting drug users and fishermen.

Democratic Republic of the Congo
The NSP of the Democratic Republic of the Congo defined key populations as men who have sex with men, people who inject drugs, sex workers and their clients, truck drivers, miners, fishermen, prisoners, men and women in uniform and youth.

Sierra Leone
The NSP of Sierra Leone stated: "Key population groups including FSW [female sex workers], MSM [men who have sex with men], people who inject drugs were identified as priority populations, alongside the fisher folks; transporters; uniformed service personnel; prisoners; miners; cross-border and informal traders; women, girls and children; youths and general population" (p. 8).

Uganda
The Ugandan NSP defined as emergent key populations prisoners, miners, plantation workers, boda-boda taxi-men, sex workers, truckers, men who have sex with men, fisher folk and uniformed services personnel.

United Republic of Tanzania
In the NSP of the United Republic of Tanzania, prisoners were included among the populations that deserve special consideration in HIV programming, but they were not included among the key populations, which were defined as men who have sex with men, sex workers and people who inject drugs.

Table 1. Mention of key populations in national strategic plans, by country

	Sex workers	Men who have sex with men	Transgender people	People who inject drugs	People in prisons and closed settings
Algeria	■	■		■	■
Angola	■	■			■
Benin	■	■		■	■
Botswana	■				
Burkina Faso	■	■		■	■
Burundi	■	■		■	■
Cape Verde	■	■		■	■
Cameroon	■	■		■	■
Central African Republic	■	■		■	■
Chad	■	■		■	■
Comoros	■			■	■
Congo	■	■		■	■
Côte d'Ivoire	■	■		■	■
Democratic Republic of the Congo	■	■		■	■
Eritrea	■	■		■	■
Ethiopia	■				■
Gambia	■			■	■
Ghana	■	■	■	■	■
Guinea	■	■		■	■
Guinea-Bissau	■	■			■
Kenya	■	■	■	■	■
Lesotho	■	■	■	■	■
Liberia	■	■		■	
Madagascar	■	■		■	■
Malawi	■	■	■		■
Mali	■	■		■	■
Mauritania	■	■			■
Mauritius	■	■	■	■	■
Mozambique	■	■		■	■
Namibia	■	■		■	■
Niger	■	■		■	■
Nigeria	■	■	■	■	■
Rwanda	■	■		■	■
Sao Tome and Principe	■	■		■	■
Senegal	■	■	■	■	■
Seychelles	■	■		■	■
Sierra Leone	■	■	■	■	■
South Africa	■	■	■	■	■
South Sudan	■	■		■	
Swaziland	■	■		■	■
Togo	■	■		■	■
Uganda	■	■		■	■
United Republic of Tanzania	■	■		■	■
Zambia	■	■		■	■
Zimbabwe	■	■	■		■
Total	45	41	10	38	42

The term "key populations" was used with varying specificity across NSPs. In some instances the term indicated a strictly defined set of populations. In these cases the working definition was stipulated near the beginning of the document, and subsequent mentions of key populations were consistent with this definition. In many NSPs, however, "key populations" was not explicitly defined, leaving the reader to infer its definition based on the populations that the term was used to describe. Sometimes this was made difficult by inconsistent usage within the NSP. For example, in the NSP for Lesotho, the executive summary defines key populations to include "commercial sex workers (CSW), men who have sex with other

men (MSM), inmates (prisoners), migrant workers, factory workers and miners, […] discordant couples and the general population" (p. 13). In contrast, the section on *HIV prevention among key populations at higher risk of HIV infection* in the same NSP included only the sub-headings sex workers, men who have sex with men, inmates, and mobile and migrant populations, thus leaving out factory workers, miners, etc.

The term "key populations" was sometimes undefined, sometimes used inconsistently within the same NSP, and sometimes applied to a long list of groups beyond the five key populations-defined by WHO.

Also, definitions for key populations were inconsistently used across NSPs, at times including many other populations. For instance, the Sierra Leone NSP listed, as priority populations, female sex workers, men who have sex with men, people who inject drugs, fisher folks, transporters, uniformed service personnel, prisoners, miners, cross-border and informal traders, women, girls, children, youths, and the general population (see box for further examples). In cases where key population definitions included large groupings of populations, it was unclear whether the particular social and legal circumstances that shape HIV risk, and which are central to the WHO definition of key populations, informed the logic of the groupings.

Some NSPs described overlaps across different key populations. In some instances, such as the NSP for Côte d'Ivoire, these overlaps helped to better describe a population. In describing the epidemic among people who inject drugs, the Côte d'Ivoire NSP mentioned that many members of this group are also men who have sex with men or sex workers. The Seychelles NSP explained the reasons that people start injecting drugs: "In recent years there have been steady increases in the number of people using drugs through injections and in sex work used to support drug addictions or for economic gains" (p. 9). In other cases overlaps helped to explain the HIV risk of populations. For instance, the Mauritius NSP mentioned that, "During 2012 there was a turnover of 4819 prison inmates, among whom the prevalence of HIV was 15.5%, mainly due to the fact that many inmates were people who inject drugs" (p. 28). The Rwanda NSP explained the high risk observed among men who have sex with men through sex work: "The last group where a substantial proportion of new infections (5 percent) was projected was among the MSM population. Based on the available data, however, this finding was interpreted to be representative of a specific subset within this population: male sex workers" (p. 5).

A few NSPs highlighted adolescents or youth among key populations. Again, some (for example, the Liberia NSP) did this with the aim of describing the demographics of the population: "People below 30 years of age make up the bulk of the 3 key population groups: 84% of FSWs are below 30 years of age including 4% teenagers 13–15 years old, 78% of MSM are below 30 years of age with about 20% between the ages of 16 and 20 years, and 61% of PWIDs [people who inject drugs] are also below 30 years of age" (p. 10). Others (for example, the Namibia NSP) described how young people come to be members of key populations: "A study on the economics of sex work shows that most sex workers interviewed entered into this trade before the age of 16 years..." (p. 77).

WHY CERTAIN POPULATIONS ARE UNDERSTOOD TO BE "KEY"

In the vast majority of NSPs, populations that were included in the definition for key populations were said to face an elevated risk and/or burden of HIV. For example, in the Burundi NSP, key populations are portrayed as having the highest infection rates and, therefore, being the most vulnerable and in need of targeted interventions.

There was variation, however, in the implicit and explicit reasoning why the risk of these populations was elevated. About two fifths of the NSPs attributed the increased risk of HIV among key populations to the impact of stigma and discrimination on *vulnerability*. For instance, in the South African NSP, "key populations" referred to those for whom "the risk of HIV infection and TB infection is also driven by inadequate protection of human rights, and by prejudice" (p. 25). Some plans went further, attributing increased vulnerability to HIV to the effect that stigma has on the health-related behaviours of members of key populations.

More than half of NSPs ascribed the higher risk of key populations to the impact of stigma and discrimination on vulnerability or on access to services.

About half of the NSPs explained the increased risk of HIV among key populations through the impact of stigma and discrimination on *access to services* for HIV prevention, testing and treatment. For instance, according to the Ghana NSP, "Widespread stigma, discrimination, and physical and verbal abuse and harassment against KPs [key populations] occurs simply because others within state institutions and the community at large disapprove of their behaviours.... KPs are increasingly marginalized … from the services they need to protect themselves from … HIV" (p. 95). The Malawi NSP described the impact of criminalization in reducing access to services: "[M]en who have sex with men are criminalized in Malawi and FSW [female sex workers] remain marginalized and subject to significant legal penalties under existing regulations. In consultations with both groups, it was evident that these groups

feel stigmatized and discriminated against by the general public as well as by healthcare and social service providers. Stigmatizing attitudes and discriminatory behaviours serve as a significant disincentive to access necessary services for the prevention, care and treatment of HIV" (p. 51).

Finally, some NSPs pointed to risky *sexual behaviour* as an explanation for elevated HIV risk. In these cases the risky sexual behaviour was not attributed to the effect of stigma. In Namibia, for example: "Most at risk populations (MARPS) are groups that are often considered to be at an elevated risk of HIV infection due to their behaviours.… Even in the context of a generalized epidemic, some people are more at-risk due to the frequency of high risk behaviours" (p. 35).

THE IMPORTANCE OF INVOLVING COMMUNITIES

Over half of NSPs acknowledged the importance of the involvement of communities of key populations in addressing the HIV epidemic. As the Kenyan NSP states, "Community-based organisations (including FBOs/NGOs/CSOs), workplaces and local community leadership play a critical role not only in promoting the ownership of the epidemic, but also in addressing the root causes of vulnerability to HIV, including skewed gender relations, harmful cultural practices, pervasiveness of stigma and discrimination and commonality of violence against Key Populations" (p. 39). Other NSPs include similar ideas. When communities of key populations were specified in the NSPs, it was most frequently communities of sex workers and of men who have sex with men. Transgender people, people in prisons and other closed settings and people who inject drugs were rarely mentioned in this context.

Some NSPs note the roles of key population communities in promoting uptake of services and helping to shape the national response to HIV.

Some NSPs pointed to an instrumental role of key-populations communities in promoting uptake of HIV services and monitoring the HIV response – especially in relation to barriers faced by key populations. Communities were also said to have a role in helping to frame the national response and engaging in advocacy to create an enabling environment for the HIV response. Finally, some NSPs highlighted the need to strengthen links with community organizations, the need to strengthen community organizations themselves and the need to engage in community empowerment activities. (See box for more discussion.)

Roles attributed to communities of key populations in national strategic plans

Facilitating access and improving services

Several NSPs acknowledged the importance of community involvement for reaching key populations and for the delivery of services. For instance, the Liberian NSP explicitly stated that access to services for women and men will be improved by supporting efforts to build the capacity of women-focused organizations and organizations for key populations. The Nigerian NSP stated that the plan was to "improve community participation, support and uptake of HIV prevention services through engagement of existing and new community structures led by key populations" (p. 60).

Monitoring

In some NSPs communities were envisioned also to play a role in monitoring. For instance, the Ugandan NSP observed that civil society will play a leading role in establishing and implementing mechanisms for ongoing monitoring of HIV/AIDS policies and performance and other factors relevant to HIV prevention, HIV care and support services, financing of programmes and in meeting structural challenges such as stigma and discrimination and gender-based inequalities. The Cameroonian NSP also mentioned that community-based organizations are to participate in the collection of information on key populations.

Involvement in framing the national response

A few NSPs include the input of key populations in the framing of the national response to HIV. For instance, the Nigerian NSP sought to ensure that civil society organizations and representatives of people living with HIV and of key populations actively participate in framing the National HIV Response Priorities and Strategies. Similarly, the Mozambican NSP recommended the "mobilization of community organizations and networks so that KP (among others) have increased representation in campaigns and solidarity movements" (p. 53).

Advocacy and accountability

Several NSPs observed that community involvement is critical for advocacy and accountability. The Togo NSP proposed to train activists in advocacy at the community leadership level against sociocultural prejudices detrimental to rights, with the goal of developing a favourable legal environment for people living with HIV and key populations. The Ugandan NSP proposed advocacy at local and national levels to hold duty bearers accountable for HIV prevention services, AIDS treatment and social support and protection for the most vulnerable communities, such as people with disabilities, key populations, women and girls.

Community strengthening

Several NSPs emphasized the strengthening of links with communities and community-based organizations as part of their strategies. The NSP for Chad, for instance, listed as one of its intended outcomes that "80% of the strengthened civil society organizations (networks, associations/NGOs, PLWHIV, and key populations) are effectively involved in implementing the national response to HIV and AIDS" (p. 55). The Burkina Faso NSP stated that, as part of the strategic plan, community structures will be mobilized as key players in the decentralization effort.

Strengthening community based organizations and civil society organizations

Several NSPs noted the need to strengthen community-based organizations (CBOs) and civil society organizations (CSOs). For instance, the NSP of Lesotho explicitly mentioned that CBOs are under-resourced, and, as a consequence, their function is suboptimal. Some NSPs mentioned that CBO and CSO services are often not sustainable. The South Sudanese NSP observed that facing challenges related to community systems is key to HIV/AIDS service delivery at sub-national levels (state, county and other lower levels). It noted that "community system actors are weak, inadequately funded and lack strong coordination mechanisms with the centre" (p. 90).

Empowerment

A few NSPs explicitly mentioned empowerment of key populations and CSOs. The Ivorian NSP proposed peer education of sex workers with the goal of esteem-building and encouraging financial security. The Mauritian NSP stated that it is important for government and nongovernmental HIV services to collaborate to provide interventions "supporting socio economic empowerment of KAPs [key affected populations] and sexual minorities in the fight against stigma and discrimination as well as for the sustainability of HIV responses. This will contribute substantially to re-integrating KAPs and sexual minorities into the social fabric of society" (p. 48). Finally, the NSP of South Sudan planned to build on the experience of partners (the community system actors) currently implementing community-based programmes and working with networks of orphans and vulnerable children and of people living with HIV to break stigma and to nurture community empowerment, thus increasing demand for and utilization of quality HIV/AIDS services and expanding their scope.

Panel 1. Interventions checklist

The following checklist was adapted from the World Health Organization *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.[1] It was used to analyse NSPs in terms of the interventions they recommend for key populations. See Tables 2–6.

HIV prevention		**Yes**	**No**
Condoms	Is **condom programming** targeting key populations recommended?		
Lubricants	Is programming for **condom-compatible lubricants** recommended?		
PrEP	Is it recommended to offer oral **pre-exposure prophylaxis (PrEP)** to key populations (as an additional prevention choice)?		
PEP	**Is post-exposure prophylaxis (PEP)** available for eligible key populations (on a voluntary basis)?		
Harm reduction for people who inject drugs		**Yes**	**No**
Is **harm reduction** part of **policy** and are **services** for people who inject drugs recommended?			
Needle and syringe	Is **needle and syringe programming** recommended?		
Opioid substitution	Is **opioid substitution therapy** recommended?		
Naloxone	Is **community distribution of naloxone** recommended?		
HIV testing services (HTS)		**Yes**	**No**
Is it recommended that **voluntary HIV testing services** be offered to all key populations both in the community and in clinical settings?			
Provider-initiated testing	Is **provider-initiated testing and counselling** recommended?		
Community-based testing	Is **community-based HIV testing and counselling** recommended?		
Lay provider testing	Is **lay provider testing** recommended?		
Self-testing	Is **self-testing** recommended?		
Assisted partner notification	Is assisted **voluntary partner notification** recommended?		
HIV treatment and care		**Yes**	**No**
Equitable ART	Is it recommended that key populations living with HIV have the same access to **antiretroviral therapy (ART)** as other populations?		
Access and adherence	Are specific services recommended to support **access and adherence** for key populations?		
PMTCT	Is **prevention of mother-to-child transmission (PMTCT)** recommended for female key populations (following the same recommendations as for women in other populations)?		
Sexual and reproductive health		**Yes**	**No**
STI screening and treatment	Is routine offer of **screening, diagnosis and/or treatment of sexually transmitted infections** for key populations recommended?		
Antenatal care	Are there recommendations that women in key populations have equitable support and access to services related to **conception and pregnancy care**?		
Critical enablers		**Yes**	**No**
Review laws – behaviour	Is there a recommendation to **review laws (and/or) policies and/or practices** that criminalize **behaviours** of key populations?		
Review laws – services	Is there a recommendation to **review laws and/or policies and/or practices** that criminalize **providing services** to key populations?		
Train health-care workers	Is sensitization training for **health-care workers** on key populations recommended?		
Train law officers	Is sensitization training for **law enforcement officers** on key populations recommended?		
Engage stakeholders	Is **engagement** of stakeholders from key population groups recommended to allow and support the implementation and scale-up of health-care services for key populations?		
Health services	Is there a recommendation that **health services be made available, accessible and acceptable** to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health (culturally appropriate care)?		
Community empowerment	Is there a recommendation for programmes to work toward implementing a package of interventions to **enhance community empowerment**?		
Violence prevention	Is there a recommendation that **violence** against people from key populations should be prevented and addressed (whether or not in partnership with key population-led organizations)?		
Violence monitoring	Is there a recommendation that all violence against people from key populations should be **monitored and/or reported** and/or that redress mechanisms should be established to provide justice?		

[1] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2016 (http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/, accessed 31 October 2017).

SEX WORKERS

REPRESENTATION OF SEX WORKERS

All reviewed NSPs mentioned sex workers, and most included sex workers as a key population (see Table 1). In a few NSPs sex workers were listed as a most-at-risk population (for example, Algeria, Ethiopia and Namibia). In most NSPs sex workers were implicitly considered to be cisgender women (that is, women whose current gender identity corresponds to their sex assigned at birth). Male sex workers were rarely included, and transgender sex workers were not included in any NSP. Sometimes this was specifically expressed (for example, in Liberia's and Senegal's NSPs only FSW (female sex workers) are mentioned in their list of abbreviations and acronyms). The NSP of South Sudan extensively addressed female sex workers as a key population and even presented a typology of female sex workers – street-based sex workers, brothel-based, home-based, venue-based (operating in bars, gambling and other night spots), hotel-based and saloon-based. In some NSPs passing reference was made to male sex work. The only reference to male sex workers in the South Sudan NSP was that "MSM are also said to exist in the context of male sex work" (p. 29). Similarly, while Rwanda's NSP listed both female sex workers and male sex workers, the policies included addressed only the needs of female sex workers; no specific activities are listed for their male counterparts. Similarly, Senegal's NSP discussed female sex work at length, whereas male sex work was addressed only in plans for operational research. The NSP for Ghana is a clear exception to this pattern: Not only were male sex workers mentioned, but the NSP also included specific plans to address the needs of male sex workers. Other NSPs, such as the South African and the Zimbabwean NSPs, discussed sex workers in general. It is unclear whether these NSPs considered male sex workers to be in this group.

Whereas some NSPs acknowledged clients of sex workers and the clients' partners as vulnerable groups, some other NSPs included clients as a key population. The South Sudanese NSP stated that, "Clients of sex workers mainly include uniformed services such as the military, migrants including cross border migrants such as truck drivers, traders and workers, and some men from the general public" (p. 27). The Malawi NSP stated that "partners of clients of female sex workers pose a big challenge in the control of the epidemic" (p. 15). Intimate partners of sex workers were rarely mentioned as a vulnerable population.

NSPs rarely mentioned young people in the context of sex work, although in a few NSPs the risks of young women engaging in transactional sex (and foregoing school) were mentioned, for instance in the NSP for Eritrea. The Lesotho NSP described how, in the previous three years, the country had experienced an increase in the number of young girls and women who engage in sex work. It said that the majority of these young girls and young women seem to be from poor family backgrounds and dysfunctional homes. Lesotho also included sex workers who are transgender as a key population.

There was wide acknowledgment in the NSPs that sex workers experience stigma and discrimination – for example, in the NSPs of Burundi, Eritrea, Mali, Namibia, South Sudan and Zambia. Some NSPs (for example, the Malawian NSP) also acknowledged that sex work is illegal in most countries and that its marginalized and illegal status necessitates that sex workers operate clandestinely, contributing to the inability to negotiate safer sex and, hence, to the transmission of HIV.

Some NSPs recognized that the stigmatized and illegal status of sex work creates a barrier to access to medical services, including HIV testing (for example, in the NSPs for Burundi, Ghana, Lesotho, Liberia, Mauritius and South Sudan) and effective HIV prevention. The Zimbabwean NSP pointed out that there is no legal framework for prevention activities with sex workers, but that the state has allowed the existence of informal lobby groups for these populations. Some NSPs (for example, Côte d'Ivoire and Rwanda) argued that sex workers should enjoy legal protection that respects the rights of sex workers and other key populations, which would enable them to benefit from the strategies of the national response. The Rwandan NSP argued that this will require advocacy with law enforcement and local authorities. Few NSPs called for the decriminalization of sex work.

Some NSPs (for example, the Democratic Republic of the Congo) asserted that sex workers should be offered assistance in finding other professional activities. The Malawian NSP observed, however, that, once women are identified as sex workers, they quite often are actively denied access to alternative income-generating opportunities.

Some NSPs recognized that the stigmatized and illegal status of sex work creates a barrier to access to services.

HIV EPIDEMIOLOGY AMONG SEX WORKERS

About two thirds of NSPs included data on the prevalence of HIV among sex workers. One quarter included measures of individual risk factors for HIV acquisition. Slightly fewer included a measure of attributable risk. Less than one tenth included data on incidence, on population size or on structural risk for HIV.

PLANNED TARGETED INTERVENTIONS FOR SEX WORKERS

Some 43 of the 45 NSPs included intervention plans for sex workers or for key populations including sex workers. These plans are summarized in the text that follows and in Table 2.

HIV prevention

Of the 43 NSPs that mentioned interventions for sex workers, 40 made specific plans to extend to this population services for prevention of sexual transmission of HIV. These NSPs all included condom programming, and about half (19) included the distribution of condom-compatible lubricants. The NSPs for Côte d'Ivoire, Eritrea, Kenya, Nigeria, South Africa and South Sudan included PrEP. In the Eritrea NSP, for instance, PrEP was directed to groups "especially susceptible to high transmission such as sex workers (FSW) and their clients…" (p. xi). The plan described PrEP as "a new approach to be added to the behavioural and other supportive interventions" (p. xi). The NSP for Nigeria set an explicit goal – "90% of the key and vulnerable populations have access to desired HIV prophylaxis by 2021" (p. vi). The South Sudan NSP went further by presenting explicit coverage targets for "female sex workers, men who have sex with men, serodiscordant couples in generalized epidemics and sexually active adolescents in hyper-endemic countries [sic]": 10% coverage by 2020 and over 30% coverage by 2030.

In relation to sex workers, PEP was included in the NSPs for Côte d'Ivoire, Democratic Republic of the Congo, Nigeria, Rwanda and South Sudan.

Harm reduction

Four NSPs mentioned harm reduction services for sex workers – Benin, Kenya, Mauritius and Seychelles. These four included needle and syringe programmes, and two of them (Kenya and Seychelles) mentioned opioid substitution therapy as well. The Seychelles NSP, for example, included harm reduction among "Priorities and Proposed Actions for Treatment and Care" (p. 20). This NSP would "provide harm reduction services, including NSP [needle and syringe programme] / NEP [needle exchange programme] & OST [opioid substitution therapy] for MSMs, IDUs [injecting drug users], SWs, prison inmates and others, as needed" (p. 20). The Mauritius NSP, rather than including sex workers in the broader category of key populations generally, considered specifically how best to deliver services to sex workers. As a rationale for co-locating services for sex workers and people who inject drugs, the NSP stated: "[S]ex workers will be more easily accessed by physically reaching them at their workplace in the evening or at Needle Exchange sites" (p. 57). No NSP included community-delivered naloxone as an intervention for sex workers.

HIV testing

The great majority of NSPs (37) that mentioned interventions for sex workers included specific HIV testing interventions. A handful of these identified specific testing modalities. Ten NSPs mentioned provider-initiated testing. For instance, the Eritrea NSP recommended offering provider-initiated testing and counselling at all contacts with "[key populations at higher risk] including sex workers, truck drivers, young women involved in transactional sex (in and out of schools) and prison inmates" (p. 28). A similar number (9) mentioned community-based testing. The Malawi NSP signalled a shift towards a targeted community-based testing strategy, focussed on "key and vulnerable populations [...] in which the highest incidence and prevalence of HIV are noted". These populations included female sex workers and clients, men who have sex with men, fishermen, estate workers, discordant couples in high prevalence geographic areas and hotspots, family members of people known to be living with HIV, young women ages 15–24 years, children, including orphans and vulnerable children, and prisoners. Only two NSPs mentioned self-testing for sex workers, and none mentioned lay testing or assisted partner notification services

HIV care and treatment

Among NSPs that mentioned interventions for sex workers, almost one third (13) expressed the goal that sex workers have equitable access to antiretroviral therapy. The Rwanda NSP recommended that sex workers and men who have sex with men be initiated on treatment regardless of CD4 count while keeping a CD4 threshold of 500 for other populations.

Table 2. Targeted interventions for sex workers, as described in national strategic plans

	HIV prevention					Harm reduction				HIV testing					HIV treatment				Sexual and repro-ductive health			Critical enablers								
	Condoms	Lubricants	PrEP	PEP	Any prevention	Needle and syringe	Opioid substitution	Naloxone	Any harm reduction	Provider-initiated testing	Community-based testing	Lay provider testing	Self testing	Assisted partner notification	Any HIV testing	Equitable ART	Access and adherence	PMTCT	Any HIV treatment	STI screening and treatment	Antenatal care	Any sex and repro health	Review laws – behaviour	Review laws – services	Train HCW	Train officers	Engage stakeholders	Health services	Community empowerment	Violence prevention	Violence monitoring	Any critical enabler
Algeria (1)	■				■					■	■				■	■	■		■	■	■	■	■		■			■	■			■
Angola (2)																																
Benin (3)	■	■			■	■			■						■	■	■		■													
Botswana (4)																																
Burkina Faso (5)	■				■										■													■	■			■
Burundi (6)										■	■				■	■	■		■	■		■			■		■	■	■			■
Cape Verde (7)	■				■										■	■			■													
Cameroon (8)	■				■										■					■		■				■		■	■			■
Central African Republic (9)	■				■										■					■		■										
Chad (10)	■				■										■					■		■					■	■				■
Comoros (11)	■				■																											
Congo (12)	■				■										■					■		■					■	■				■
Côte d'Ivoire (13)	■	■	■	■	■					■	■		■		■												■		■	■		■
Democratic Republic of the Congo (14)	■	■		■	■					■	■				■					■		■	■					■	■			■
Eritrea (15)	■	■	■		■					■					■	■			■				■			■			■	■		■
Ethiopia (16)	■				■					■					■					■	■	■										
Gambia (17)															■					■		■					■	■		■		■
Ghana (18)	■	■			■						■				■					■		■	■	■						■		■
Guinea (19)	■	■			■										■									■			■	■	■			■
Guinea-Bissau (20)	■				■										■								■									■
Kenya (21)	■	■	■		■	■	■		■						■		■		■	■		■	■	■	■	■	■	■		■		■
Lesotho (22)	■	■			■					■	■				■	■			■	■		■	■	■	■							■
Liberia (23)	■	■			■										■					■		■							■			■
Madagascar (24)	■				■										■												■	■				■
Malawi (25)	■	■			■					■					■					■		■	■		■	■				■		■
Mali (26)	■	■			■										■	■			■						■		■	■				■
Mauritania (27)	■				■										■					■		■										
Mauritius (28)	■	■			■	■			■											■		■	■	■				■	■			■
Mozambique (29)	■	■			■																											
Namibia (30)	■				■										■					■		■										
Niger (31)	■	■			■						■				■								■		■		■	■	■			■
Nigeria (32)	■	■	■	■	■																			■								■
Rwanda (33)	■			■	■										■	■	■		■	■		■		■	■	■	■	■		■		■
Sao Tome and Principe (34)	■				■										■																	
Senegal (35)	■	■			■										■					■		■				■			■			■
Seychelles (36)						■	■		■						■																	
Sierra Leone (37)	■	■			■										■		■		■				■		■		■	■	■	■		■
South Africa (38)	■		■		■										■					■		■						■				■
South Sudan (39)	■	■	■	■	■												■	■	■	■	■	■		■	■	■	■	■	■	■		■
Swaziland (40)	■				■										■		■		■	■		■		■			■	■				■
Togo (41)	■	■			■					■					■	■			■				■	■		■		■				■
Uganda (42)	■				■										■	■	■		■	■		■		■			■	■				■
United Republic of Tanzania (43)	■				■						■				■	■	■		■	■		■		■	■		■	■				■
Zambia (44)	■				■					■	■		■		■	■	■		■	■		■		■			■	■				■
Zimbabwe (45)	■				■										■	■		■	■	■	■	■	■	■			■	■		■		■
Total	40	19	6	5	40	4	2	0	4	10	9	0	2	0	37	13	11	2	17	26	4	26	13	14	12	8	17	24	14	10	0	33

Notes: Interventions are described in Panel 1.
Numbers in parentheses after country names refer to the list of NSPs at the back of this publication.

It noted that "a corollary of this approach is that it requires more extensive outreach to bring broader populations under treatment". Similarly, the Zambia NSP, under its programme objective to expand HIV treatment, named as a programme strategy: "Strengthen mobile ART services in rural areas and hard to reach populations including inmates, migrants, persons with disabilities, sex workers and their clients, MSM and PWUDs [people who use drugs]" (p. 52). About one quarter of NSPs (11) that mentioned interventions for sex workers also recommended specific interventions to support access and adherence to antiretroviral therapy.

The NSPs for Zimbabwe and South Sudan recommended that sex workers have equitable access to PMTCT services. For instance, the Zimbabwe NSP included as a key future focus that sex workers should have easy access to PMTCT services, such as mobile services.

Reproductive health

Almost two thirds of NSPs (26) that included interventions for sex workers recommended routine screening, diagnosis and/or treatment of STIs. For instance, the Ethiopia NSP set a focus for the period of the NSP to "reduce the incidence of the common sexually transmitted infections among the population, with a special emphasis to most at risk and vulnerable population groups and intensify appropriate diagnosis and treatment of STI through overhauling Syndromic case management at all service delivery points" (p. 31). Included among the interventions to achieve this goal was the expansion of "user friendly STIs and reproductive health services to MARPs & other vulnerable populations". Sex workers were included among MARPS. The Malawi NSP made recommendations about community-delivered services in response to community consultations with men who have sex with men and female sex workers in which it was reported that "health care workers are often not receptive to these groups. This deters health-seeking behaviours (especially for STIs) and discourages KPs who do access services from reporting fully on their sexual activities, which may result in them being provided with incomplete or inappropriate services" (p. 43).

Almost two-thirds of NSPs that included interventions for sex workers recommended routine STI screening, diagnosis and/or treatment.

Only four NSPs, those of Algeria, Ethiopia, South Sudan and Zimbabwe, included a recommendation to address services related to conception and pregnancy care to sex workers.

Critical enablers

Three quarters of NSPs (33) that mentioned interventions for sex workers included recommendations for structural interventions. Among these, the most common recommendation was that health services be made available, accessible and acceptable to sex workers. For example, the Gambia NSP recommended that a strategy for marginalized groups and key affected population be implemented, noting that, "Poverty, migration, civil unrest, stigma and discrimination of key affected populations ... marginalize people, increasing their vulnerability to infection and reducing their access to services" (p. 35). In particular, "the strategy emphasizes gender equity and prevention of gender-based violence and the particular need for these efforts in FSW and other marginalized groups and key populations' interventions" (p. 36).

The most common critical enabler recommended for sex workers was making health services available, accessible and acceptable.

Nearly one third of NSPs (13) that included interventions for sex workers mentioned the criminalization of sex work as an important barrier to effective prevention and access to care. The Zimbabwe NSP, under a section entitled "causes of access inequity to services" described the illegal status of sex work as a legal barrier. Later in the document, listed as a key area of attention, was: "Active social dialogue on inclusion, morality, selling sex and MSM" (p. 58). Actual decriminalization of specific behaviours of key populations is mentioned in only a few NSPs and only without referring to specific key populations; increasing access to services is the primary aim. For instance, the Kenya NSP proposes to adapt legal frameworks to decriminalize activities of key populations and, thereby, increase their demand for and access to HIV services.

A small number of NSPs mentioned all categories of critical enabler interventions except violence monitoring, which no NSP mentioned.

MEN WHO HAVE SEX WITH MEN

REPRESENTATION OF MEN WHO HAVE SEX WITH MEN

Almost all NSPs (41 of 45) mentioned men who have sex with men as one of the key populations (see Table 1). The four NSPs without reference to this population were Botswana, Comoros, Ethiopia and Gambia. In the case of Botswana, research docmenting HIV prevalence and human rights violations among men who have sex with men had already been conducted before the national strategic plan came into force.[1]

Several NSPs acknowledged that the population of men who have sex with men intersects with other populations. For instance, the NSPs of Malawi and Liberia stated that large proportions of men who have sex with men also have female partners. The NSPs of Mauritius and South Africa used identical definitions for men who have sex with men: "males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This description includes men who self-identify as heterosexual but have sex with other men" (p. 11 and p. 6, respectively). Rwanda's NSP stated that, among men who have sex with men, new infections were most likely to occur among those who are sex workers. Malawi's NSP noted that some men who have sex with men were also prisoners. Lesotho's NSP made a special mention of "herd boys" as one of the groups at increased risk for HIV infection due to engagement in sex with men, in addition to sexual abuse; limited access to food and nutrition care; and socioeconomic vulnerabilities such as "a compromised right to attend school, risky cultural and social practices" (p. 55).

Many NSPs acknowledged the marginalization in their societies of men who have sex with men.

Many NSPs acknowledged the marginalization in their societies of men who have sex with men and its consequences. The NSP for Madagascar mentioned that, even though sex between men is not criminalized in that country (at least not among men 21 years and older), society shuns these men, and they are subjected to verbal abuse and stigma. The NSP of South Sudan stated that, as in most other African countries, men who have sex with men are not socially tolerated: It described the social and political environment in South Sudan as hostile to men who have sex with men, with the risk of being murdered or "summary dismissal from the country" (p. 19). Grouping men who have sex with men with sex workers and people living with HIV, the Malawian NSP referred to the societal stigma that these groups experience, including stigma from medical personnel, the family and community and in the workplace, but also self-stigmatization. Stigmatization and discrimination keep the population of men who have sex with men underground, the NSP notes.

Fewer NSPs mentioned that homosexuality is illegal in their countries, even though this was the case in most of the included countries at the time that these NSPs were developed. NSPs that noted the illegality of homosexuality included those of Lesotho, Malawi, Nigeria, South Sudan, Zambia and Zimbabwe. The Nigerian NSP mentioned the Same Sex Marriage Prohibition Act, which was signed into law in January 2014. The Zimbabwean NSP noted that sex between people of the same sex is illegal and that this creates a barrier to HIV prevention. The NSP of South Sudan pointed out that:

> The punishment for being an MSM [man who has sex with men] is stiff, and could range from flogging to the death penalty. Due to legal implications, MSMs may not logically be expected to attend public BCC [behaviour change communication] talks as MSM or receive specific types of condoms and other commodities in public spaces outside of their network. Specific civil society actors and strategies are therefore required to provide HIV preventive and treatment services to MSM in the interest of Public Health as guaranteed to citizens in article 35 of South Sudan's Transitional Constitution. [p. 29]

Many NSPs note that marginalization, stigmatization and criminalization have several implications for HIV prevention and care. On the personal level, the NSP for Namibia, for instance, stated that the stigma associated with homosexuality may inhibit some men from identifying themselves as gay or bisexual, even though they have sex with other men, and that some men who have sex with both men and women do not identify themselves as gay or bisexual. On the interpersonal level, the NSP of Lesotho, for instance, mentioned that stigma and discrimination make it difficult for men who have sex with men to acknowledge their status publicly. The Malawian NSP noted growing evidence of violence against men and boys who have sex with men, both from members of the general population (including friends and family) and in the context of intimate partner relationships. The Burundian NSP mentioned that access to HIV prevention and care services is limited by the effect of the penal code, which outlaws same-sex sexual relations.

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[1] For example, see Baral S, Trapence G, Motimedi F, Umar E, Iipinge S, Dausab F et al. HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PloS One*. 2009;4(3):e4997.

A few NSPs also stated that the social and legal situation directly or indirectly increases transmission risk for men who have sex with men. The Ghanaian NSP, for instance, stated that punitive laws, widespread and entrenched stigma, harassment and/or arrest by police increase the vulnerability of men who have sex with men. The Liberian NSP referred to the very limited experience and weak capacity of local civil society service providers as the main reasons that men who have sex with men, as well as other key populations, have poor access to HIV prevention information and services. Several NSPs mentioned that the fact that men who have sex with men live in fear of being stigmatized, discriminated against and marginalized has compromised their uptake of services. The South Sudan NSP explicitly stated that the significant number of new infections among men who have sex with men and anecdotal evidence show that the social and legal situation affects their health-seeking behaviour and acts as a barrier in a number of ways. The NSP also referred to the human rights- and policy-related barriers to service and commodity access and use. The NSPs of Benin, Malawi, Mauritius, Nigeria and South Africa include similar language. The Ghanaian NSP states that stigma prevents men who have sex with men from using HIV prevention and treatment services, resulting in their continuing risk of acquiring and transmitting HIV. Finally, the Lesotho NSP explicitly mentioned that the illegality of sex between men makes it difficult to develop and sustain targeted interventions for this population.

HIV EPIDEMIOLOGY AMONG MEN WHO HAVE SEX WITH MEN

About half of all NSPs included measures of HIV prevalence among men who have sex with men. Close to one quarter included risk factors for HIV acquisition, and slightly less than one fifth included a measure of attributable risk. Even fewer included measures of population size or incidence, and none included measures on structural risk.

PLANNED TARGETED INTERVENTIONS FOR MEN WHO HAVE SEX WITH MEN

Some 39 of the 45 NSPs included intervention plans for men who have sex with men or for key populations including men who have sex with men. The text that follows and Table 3 summarize these plans.

HIV prevention

Nearly all NSPs with strategies for men who have sex with men plan services to prevent sexual transmission of HIV.

Of the 39 NSPs that mentioned interventions for men who have sex with men, 38 made specific plans to extend HIV services to this population to reduce sexual transmission of HIV. All but one of these included condom programming, and about three fifths included condom-compatible lubricants. For example, the Côte d'Ivoire NSP recommended implementing a package of services for sex workers and men who have sex with men in areas of high HIV infection rates. Both health professionals and community actors and associations would be involved. This package would be offered in facilities that distribute medications and have testing kits. Clients would benefit from accompanying peer education and psychosocial support.

Six NSPs (Côte d'Ivoire, Ghana, Kenya, Nigeria, South Africa and South Sudan) included PrEP for men who have sex with men. Sometimes PrEP was integrated with other services. For instance, the South Sudan NSP set, as a top priority, "Integrated peer-led interventions with key populations". PrEP appeared as one of the interventions to be delivered through peer-led programmes, although these programmes were not described in detail. The South Sudan NSP also included PEP among the interventions to be delivered through peer-led programmes. In total, seven NSPs included PEP among services for men who have sex with men or for key populations where the plans include men who have sex with men as a key population.

Harm reduction

The NSPs for Kenya and Seychelles mentioned harm reduction services for men who have sex with men. Both included needle and syringe programmes and opioid substitution therapy; neither mentioned naloxone. The Seychelles NSP, in its proposed actions for "key populations (MSM, PWID, and SW) and high-risk groups (prison inmates, migrants and young people)" proposed harm reduction services following WHO and UNAIDS guidelines. In similar fashion the Kenya NSP recommended scaling up needle and syringe programmes and initiating "medically assisted therapy for opioid dependents" among "key populations and vulnerable populations". This NSP included men who have sex with men in its definition of key populations.

Table 3. Targeted interventions for men who have sex with men, as described in national strategic plans

	HIV prevention					Harm reduction				HIV testing						HIV treatment				Sexual and repro-ductive health			Critical enablers								
	Condoms	Lubricants	PrEP	PEP	Any prevention	Needle and syringe	Opioid substitution	Naloxone	Any harm reduction	Provider-initiated testing	Community-based testing	Lay provider testing	Self testing	Assisted partner notification	Any HIV testing	Equitable ART	Access and adherence	PMTCT	Any HIV treatment	STI screening and treatment	Antenatal care	Any sex and repro health	Review laws – behaviour	Review laws – services	Train HCW	Train officers	Engage stakeholders	Health services	Community empowerment	Violence prevention	Violence monitoring	Any critical enabler
Algeria (1)	■				■					■	■				■	■	■		■	■		■	■		■			■	■			■
Angola (2)																																
Benin (3)	■	■			■										■	■	■		■													
Botswana (4)																																
Burkina Faso (5)	■				■										■													■	■			■
Burundi (6)		■			■					■	■				■	■	■		■	■		■			■		■	■	■			■
Cape Verde (7)	■				■										■	■			■													
Cameroon (8)	■				■										■					■		■				■		■	■			■
Central African Republic (9)	■				■										■					■		■										
Chad (10)	■	■			■										■					■		■					■	■				■
Comoros (11)																																
Congo (12)	■	■			■										■					■		■					■	■				■
Côte d'Ivoire (13)	■	■	■	■	■					■	■		■		■													■	■	■		■
Democratic Republic of the Congo (14)	■	■		■	■					■	■				■					■		■						■				■
Eritrea (15)																																
Ethiopia (16)																																
Gambia (17)																																
Ghana (18)	■	■	■	■	■						■		■		■		■		■	■		■	■	■	■	■				■		■
Guinea (19)	■	■			■										■									■			■	■	■			■
Guinea-Bissau (20)	■				■										■								■									■
Kenya (21)	■	■	■		■	■	■		■						■		■		■	■		■	■	■	■	■	■	■		■		■
Lesotho (22)	■	■			■					■	■				■	■			■	■		■	■	■	■							■
Liberia (23)	■	■			■										■					■		■							■			■
Madagascar (24)	■	■			■										■												■	■				■
Malawi (25)	■	■		■	■					■	■				■					■		■	■		■	■				■		■
Mali (26)	■	■			■										■										■		■	■				■
Mauritania (27)	■				■										■					■		■										
Mauritius (28)	■				■																		■	■				■	■			■
Mozambique (29)	■	■			■																											
Namibia (30)	■				■										■					■		■										
Niger (31)	■	■			■						■				■								■		■		■	■	■			■
Nigeria (32)	■	■	■	■	■																			■								■
Rwanda (33)	■	■		■	■										■	■	■		■	■		■		■	■	■	■	■		■		■
Sao Tome and Principe (34)	■				■										■																	
Senegal (35)	■	■			■										■					■		■				■			■			■
Seychelles (36)						■	■		■						■																	
Sierra Leone (37)	■	■			■										■		■		■				■		■		■	■	■	■		■
South Africa (38)	■		■		■															■		■						■				■
South Sudan (39)	■	■	■	■	■												■		■	■		■		■	■	■	■	■	■	■		■
Swaziland (40)	■				■										■		■		■	■		■		■	■		■	■				■
Togo (41)	■	■			■					■					■	■			■				■	■		■		■				■
Uganda (42)	■				■										■	■	■		■	■		■		■			■	■				■
United Republic of Tanzania (43)	■				■						■				■	■	■		■	■		■		■	■		■	■				■
Zambia (44)	■				■					■	■		■		■	■	■		■	■		■		■			■	■				■
Zimbabwe (45)	■				■										■	■			■	■		■	■	■			■	■				■
Total	37	22	6	7	38	2	2	0	2	8	10	0	3	0	33	11	12	0	16	23	0	23	11	14	13	8	16	23	12	7	0	31

Notes: Interventions are described in Panel 1.
Numbers in parentheses after country names refer to the list of NSPs at the back of this publication.

HIV testing

More than four fifths (33) of NSPs that mentioned interventions for men who have sex with men included HIV testing for this group. About one third of these included the specific modalities to be used: Ten NSPs mentioned community-based testing and eight referred to provider-initiated testing. The NSP for Democratic Republic of the Congo included the recommendation that all sectors involved in the HIV response use programmes such as mobile facilities to promote both testing and counselling and symptom management according to key population needs.

Three NSPs (Côte d'Ivoire, Ghana and Zambia) mentioned self-testing. The Ghana NSP planned to pilot-test self-testing, as this approach was not yet approved. The Zambia NSP mentioned that introduction of self-testing was under consideration.

HIV care and treatment

Among NSPs that mentioned interventions for men who have sex with men, about one quarter (11) stated that this population should have equitable access to antiretroviral therapy. About the same number (12) recommended specific interventions to support access and adherence to antiretroviral therapy. The NSP for Togo, for instance, mentioned a need to improve access to ART among key populations (which included men who have sex with men). It also recommended supporting community mobilization to bolster HIV diagnosis and treatment.

Sexual and reproductive health

Just over half (23) of NSPs that mentioned interventions for men who have sex with men recommended routine screening, diagnosis and/or treatment of sexually transmitted infections. The Central African Republic NSP mentioned the creation and implementation of a specific programme for access to HIV/STI prevention for men who have sex with men, including in crisis situations. Among strategies to reduce the prevalence of genital ulcers, the Swaziland NSP set as a priority to "ensure targeted key populations' STI service delivery". In this NSP key populations included men who have sex with men.

Critical enablers

Three quarters (31) of the NSPs that mentioned interventions for men who have sex with men recommended structural interventions. The most common recommendation, mentioned by 23 NSPs, was that health services be made available, accessible and acceptable to men who have sex with men. For example, the Gambia NSP stated that "no person should be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location or level of literacy" (p. 36). No NSP mentioned violence monitoring activities.

While 11 NSPs recommended attention to legal aspects, only a few, including the Kenya and Lesotho NSPs, mentioned decriminalization of behaviours of key populations, and, as with sex workers, they did so without specifically mentioning men who have sex with men. For instance, the Eritrean NSP mentions, as an essential strategy for creating an enabling environment, supportive legislation including decriminalization of certain behaviours of key populations. The other NSPs propose addressing legal barriers that prevent key populations from accessing care. For instance, the Ugandan NSP proposes a "campaign for revision of harmful laws and policies that deter PLHIV, OVC, key populations and vulnerable groups from accessing social support and protection interventions" (p. 36).

TRANSGENDER PEOPLE

REPRESENTATION OF TRANSGENDER PEOPLE

Only 10 of 45 NSPs mentioned transgender people, and only four offered intervention strategies.

Only 10 of 45 NSPs mentioned transgender people (see Table 1). They were specifically included in the definition of key populations in the NSPs of Ghana, Kenya, Lesotho, Malawi, Mauritius, Nigeria, Senegal, Sierra Leone, South Africa and Zimbabwe. In a few of these NSPs – for example, the Mauritian, Nigerian and Sierra Leonean NSPs – transgender people figured only marginally. This is likely because little information is available about HIV among transgender people. In most cases the gender of transgender people was not specified. When the gender of transgender people was specified, NSPs addressed transgender women.

The Malawian NSP included transgender people in the discussion of how gender inequalities and harmful norms, which promote unsafe sex and reduce access to HIV and sexual reproductive health services, continue to drive the transmission of HIV. It also addressed transgender women in a discussion about reducing discrimination in access to services and presented, as an example of the failings of health services, the "failure on the part of clinic staff to distinguish between gay men, transgender women and heterosexually identified men who have sex with men, leading to provision of inappropriate HIV counselling services" (p. 50).

Only the NSPs of Mauritius and South Africa defined the category of transgender. They used identical definitions. Transgender people were described as people who "express a gender identity that is different from their birth sex" (p. 12 and p. 7, respectively). The South African NSP also explained that transgender people are at high risk of being HIV-positive and, due "to the lack of knowledge and understanding of this community, and because of stigma, this population is often at risk for sexual abuse and marginalized from accessing prevention, care and treatment services" (p. 26).

The Mauritian NSP referred to transgender people as a subpopulation of men who have sex with men. It stated, in the context of a situation analysis of clinical service provision, that: "Hard to reach populations such as sex workers and men who have sex with men, including the transgender, are provided with condoms through outreach by peers" (p. 31).

The Nigerian NSP observed, in a discussion of the national response to HIV and AIDS, that, regarding human rights and legal issues, few activities are planned "to engage" transgender people. No additional information was provided.

The Senegalese NSP for 2014–2017 included transgender people in its discussion. It listed transgender people as one of the populations that were still insufficiently addressed by HIV interventions, together with several other populations, such as young people from key populations, post-menopausal women, "so-called stable heterosexual couples," victims of gender-based violence, mobile populations in border areas and others. The NSP acknowledged that little is known about transgender people (as well as lesbian women). The plan proposed national studies from a gender perspective to better refine prevention and care strategies for key populations, including transgender people as well as people with disabilities, lesbian women, widows and divorced women and people involved in transactional sex and intergenerational relationships.

The Zimbabwean NSP referred to transgender people only in describing the global target for "ending AIDS by 2030" by increasing to 90% the coverage of "services (including PrEP as appropriate) for female sex workers, transgender, and men who have sex with men" (p. 65). National targets for PrEP among these populations were not specified, however.

HIV EPIDEMIOLOGY AMONG TRANSGENDER PEOPLE

Only the NSP of Sierra Leone included HIV prevalence figures for transgender people. It presented a prevalence estimate of 22.4% for "Transgender M to F", and a prevalence estimate of 4.3% for "Transgender F to M". The report observes that there are major variations in HIV prevalence among women and men across districts in Sierra Leone and discusses "the granular nature of the epidemic in Sierra Leone; and the need for a similarly aligned HIV response" (p. 4).

PLANNED TARGETED INTERVENTIONS FOR TRANSGENDER PEOPLE

Of the 10 NSPs that mentioned transgender people, only four included intervention plans for this population (see Table 4). The Sierra Leone NSP, in a table summarizing strategies and expected results for the NSP, included the goal: "Key populations, including sex workers, men who have sex with men, transgender, PWID, EVDS [Ebola virus disease survivors], prisoners, TB patients, migrant workers (fisher-folk, miners, transporters) and traders, and uniformed personnel that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD [Ebola virus disease] and TB increased from 2015 level to 90% by 2020" (p. xvi). This intended outcome was associated with a set of "strategic outputs" that included increased access to and utilization of targeted combination prevention interventions.

Like the Sierra Leone NSP, the Mauritius NSP included transgender people in a broader category of key affected populations and articulated intervention plans for that category: "Key Affected Populations are often victims of gender-based violence and are often incapable of negotiating condom use. This is particularly true for sex workers, men having sex with men, trans-genders and prison inmates, who do not report the cases or pursue the matter because of ignorance of their rights and fear of recrimination. The NSF [National Strategic Framework] aims to empower vulnerable populations to practice safe sexual behaviour in order to avoid HIV infection. In addition, prison officers will receive training in order to be better able to protect vulnerable populations".

In contrast to the NSPs discussed above, the South Africa NSP lists the populations included in the category "key populations that are at higher risk for HIV infection". Transgender people are included in this category along with young women between ages of 15 and 24, people living or working along national roads and highways, people living in informal settlements, migrant populations, young people who are not attending school, people with the lowest socio-economic status, uncircumcised men, persons with disabilities, men who have sex with men, sex workers and their clients, people who use illegal substances (especially those who inject drugs), alcohol abusers and orphans and other vulnerable children and youth. Interventions were addressed to the key populations group without elaborating the special needs of transgender people. For example, sub-objectives under the main objective of preventing new HIV, STI and TB infections included: "Make accessible a package of sexual and reproductive health services to prevent HIV and STIs, with emphasis on key populations, including strengthening of the syndromic management of STIs in both the public and private health sectors" (p. 22).

Finally, in the Ghana NSP the inclusion of transgender people is unclear. The definition for key populations at the beginning of the document includes transgender persons. The body of the document, however, does not include transgender people in elaborated plans for the HIV response. Elsewhere, the plan notes that, "Most-at-risk populations (MARPs) are population groups that are highly exposed to HIV.... The national HIV response recognises female sex workers (FSWs), clients of FSWs, men who have sex with men (MSM), persons who inject drugs (PWIDs), and prisoners as MARP groups at high risk … along with persons living with HIV (PLHIV) as key population (KP) groups with high risk of transmitting HIV" (p. 93).

Table 4. Targeted interventions for transgender people, as described in national strategic plans

	HIV prevention					Harm reduction				HIV testing						HIV treatment				Sexual and repro-ductive health			Critical enablers									
	Condoms	Lubricants	PrEP	PEP	Any prevention	Needle and syringe	Opioid substitution	Naloxone	Any harm reduction	Provider-initiated testing	Community-based testing	Lay provider testing	Self testing	Assisted partner notification	Any HIV testing	Equitable ART	Access and adherence	PMTCT	Any HIV treatment	STI screening and treatment	Antenatal care	Any sex and repro health	Review laws – behaviour	Review laws – services	Train HCW	Train officers	Engage stakeholders	Health services	Community empowerment	Violence prevention	Violence monitoring	Any critical enabler
Algeria (1)																																
Angola (2)																																
Benin (3)																																
Botswana (4)																																
Burkina Faso (5)																																
Burundi (6)																																
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Central African Republic (9)																																
Chad (10)																																
Comoros (11)																																
Congo (12)																																
Côte d'Ivoire (13)																																
Democratic Republic of the Congo (14)																																
Eritrea (15)																																
Ethiopia (16)																																
Gambia (17)																																
Ghana (18)																							■	■						■		■
Guinea (19)																																
Guinea-Bissau (20)																																
Kenya (21)																																
Lesotho (22)																																
Liberia (23)																																
Madagascar (24)																																
Malawi (25)																																
Mali (26)																																
Mauritania (27)																																
Mauritius (28)	■				■																		■	■				■	■			■
Mozambique (29)																																
Namibia (30)																																
Niger (31)																																
Nigeria (32)																																
Rwanda (33)																																
Sao Tome and Principe (34)																																
Senegal (35)																																
Seychelles (36)																																
Sierra Leone (37)	■	■			■										■		■		■				■		■		■	■	■	■		■
South Africa (38)	■		■		■															■		■						■				■
South Sudan (39)																																
Swaziland (40)																																
Togo (41)																																
Uganda (42)																																
United Republic of Tanzania (43)																																
Zambia (44)																																
Zimbabwe (45)																																
Total	3	1	1	0	3	0	0	0	0	0	0	0	0	0	1	0	1	0	1	1	0	1	3	2	1	0	1	3	2	2	0	4

Notes: Interventions are described in Panel 1.
Numbers in parentheses after country names refer to the list of NSPs at the back of this publication.

PEOPLE WHO INJECT DRUGS

REPRESENTATION OF PEOPLE WHO INJECT DRUGS

People who inject drugs are included in two thirds of NSPs – 31 of 45 – and most often are referred to as a key population or a key affected population. Ghana's and Namibia's NSPs categorize people who inject drugs as a most-at-risk population, or MARP.

NSPs describe the significance of people who inject drugs in different ways. Ghana's NSP mentions in general about MARPs that they are key drivers of the HIV epidemic, as they have HIV prevalence several times that in the general population. Furthermore, they constitute a bridging population spreading HIV to the "general population" where HIV prevalence is low. The Mauritius NSP lists people who inject drugs as a population for whom reduction of HIV transmission has always been one of the most important elements in the national response to HIV and AIDS.

Intersections of people who inject drugs with other key populations are rarely mentioned. One exception is the NSP of Seychelles. It mentions a steady increase in recent years in the number of people injecting drugs and selling sex in order to support drug addiction.

Some NSPs mention the social circumstances of people who inject drugs or how these circumstances affect their risk. Kenya's NSP, for instance, mentioned that police beat people who inject drugs. The Liberian NSP stated that stigma and discrimination and the very limited experience and weak capacity of local civil society service providers are the main reasons that people who inject drugs (as well as men who have sex with men and female sex workers) have poor access to HIV prevention information and services. The NSP of Mauritius also emphasizes the high level of stigma and discrimination that people who inject drugs experience and how that limits access to HIV prevention and care services that respond to their specific needs. Other NSPs, such as that of Algeria, comment more generally that ongoing stigma may reduce access to care. Kenya's NSP explicitly mentions several violations of human rights that people who inject drugs may experience in relation to HIV treatment. These include the denial of antiretroviral therapy on the assumption that they will be "unreliable patients" and reduced access to ART services because people fear arrest at health facilities or they actually are arrested.

HIV EPIDEMIOLOGY AMONG PEOPLE WHO INJECT DRUGS

About one third of NSPs reported data on HIV prevalence among people who inject drugs, and one fifth included information on individual risk factors for HIV acquisition. Fewer than one tenth of NSPs included information on attributable risk, population size or incidence.

PLANNED TARGETED INTERVENTIONS FOR PEOPLE WHO INJECT DRUGS

Of the 38 NSPs that mentioned people who inject drugs, 32 included intervention plans for people who inject drugs or for key populations including people who inject drugs. The text that follows and Table 5 summarize these plans.

HIV prevention

Of the 32 NSPs that mentioned interventions for people who inject drugs, 23 made specific plans to extend services to this population for prevention of sexual transmission of HIV. All of these NSPs mentioned condom programming, but only nine included condom-compatible lubricants. For example, the Benin NSP sought to reduce new HIV infections by 30% with an emphasis on key populations (men who have sex with men, sex workers and their clients and people who inject drugs) and vulnerable populations (prisoners, mobile populations, youth and adolescents). To achieve this goal, the NSP recommended making male and female condoms and condom-compatible lubricants accessible to key and vulnerable populations.

The NSPs for Côte d'Ivoire, Kenya, Nigeria and South Africa also included PrEP for people who inject drugs, and the NSPs for Côte d'Ivoire, Democratic Republic of the Congo and Nigeria included PEP.

Table 5. Targeted interventions for people who inject drugs, as described in national strategic plans

	HIV prevention					Harm reduction				HIV testing						HIV treatment				Sexual and repro-ductive health			Critical enablers								
	Condoms	Lubricants	PrEP	PEP	Any prevention	Needle and syringe	Opioid substitution	Naloxone	Any harm reduction	Provider-initiated testing	Community-based testing	Lay provider testing	Self testing	Assisted partner notification	Any HIV testing	Equitable ART	Access and adherence	PMTCT	Any HIV treatment	STI screening and treatment	Antenatal care	Any sex and repro health	Review laws – behaviour	Review laws – services	Train HCW	Train officers	Engage stakeholders	Health services	Community empowerment	Violence prevention	Violence monitoring	Any critical enabler
Algeria (1)	■				■	■			■	■	■				■	■	■		■	■		■	■		■			■	■			■
Angola (2)																																
Benin (3)	■	■			■										■	■	■		■													
Botswana (4)																																
Burkina Faso (5)	■				■	■			■						■													■	■			■
Burundi (6)										■	■				■										■		■	■	■			■
Cape Verde (7)	■				■										■	■			■													
Cameroon (8)	■				■										■					■		■				■		■	■			■
Central African Republic (9)																																
Chad (10)																																
Comoros (11)																																
Congo (12)																																
Côte d'Ivoire (13)	■		■	■	■					■	■		■		■												■		■	■		■
Democratic Republic of the Congo (14)	■			■	■					■	■				■					■		■						■				■
Eritrea (15)						■	■		■																							
Ethiopia (16)																																
Gambia (17)															■																	
Ghana (18)	■	■			■						■				■					■		■	■	■						■		■
Guinea (19)	■				■	■			■						■									■				■	■			■
Guinea-Bissau (20)																																
Kenya (21)	■	■	■		■	■	■		■						■		■		■	■		■	■	■	■	■	■	■		■		■
Lesotho (22)																																
Liberia (23)	■	■			■										■					■		■							■			■
Madagascar (24)	■				■	■			■														■				■	■				■
Malawi (25)																																
Mali (26)	■				■	■			■						■	■			■						■		■	■				■
Mauritania (27)																																
Mauritius (28)	■				■	■	■	■	■						■								■	■				■	■			■
Mozambique (29)	■	■			■																											
Namibia (30)															■					■		■										
Niger (31)																																
Nigeria (32)	■	■	■	■	■	■			■															■								■
Rwanda (33)	■				■																											
Sao Tome and Principe (34)						■			■						■																	
Senegal (35)	■	■			■	■	■		■						■					■		■				■			■			■
Seychelles (36)						■	■		■						■																	
Sierra Leone (37)	■	■			■										■		■		■				■		■		■	■	■	■		■
South Africa (38)	■		■		■															■		■						■				■
South Sudan (39)						■	■		■																							
Swaziland (40)							■		■						■		■		■	■		■		■	■		■	■				■
Togo (41)	■	■			■					■					■	■			■				■	■		■		■				■
Uganda (42)																																
United Republic of Tanzania (43)	■				■	■			■		■				■	■	■		■	■		■		■	■		■	■				■
Zambia (44)	■				■	■			■	■	■		■		■	■	■		■	■		■		■			■	■				■
Zimbabwe (45)						■	■	■	■																							
Total	23	9	4	3	23	16	8	2	17	6	7	0	2	0	24	7	7	0	10	12	0	12	7	9	7	4	9	16	10	4	0	21

Notes: Interventions are described in Panel 1.
Numbers in parentheses after country names refer to the list of NSPs at the back of this publication.

Harm reduction

About half (17) of the 32 NSPs that addressed interventions for people who inject drugs mentioned harm reduction services. Of these, 16 mentioned needle and syringe programmes, and eight mentioned opioid substitution therapy. Only the Mauritius and Zimbabwe NSPs mentioned naloxone. In the Guinea NSP a risk-reduction approach for people who inject drugs would include sterile injection kits and needle exchanges, sensitization and education, social support and distribution of condoms.

HIV testing

About three quarters (24) of NSPs that mentioned interventions for people who inject drugs included targeted HIV testing interventions for this group. The Liberia NSP recommended a needle and syringe exchange programme comprising injecting equipment packs (needles, syringes and paraphernalia), overdose prevention, HIV testing and counselling, HIV/AIDS prevention education, condom distribution and referral to substance abuse treatment and other medical and social services. In addition, the Liberia NSP included methadone substitution therapy and hepatitis B vaccination for people who inject drugs. A handful of NSPs mentioned community-based testing as well as provider-initiated testing for this key population.

HIV care and treatment

About one fifth (7) of NSPs that mentioned interventions for people who inject drugs noted the need to ensure that members of this population have equitable access to antiretroviral therapy. This mention usually came in reference to a broader grouping of key populations. The United Republic of Tanzania NSP, for instance, aimed to strengthen treatment-as-prevention interventions for specific groups, including key populations. People who inject drugs were included in the NSP as a key population.

Sexual and reproductive health

About one third (12) of NSPs that mentioned interventions for people who inject drugs recommended routine screening, diagnosis and/or treatment of sexually transmitted infections among people who inject drugs. The Ghana NSP included the following HIV interventions for programmes serving people who inject drugs: "condom and condom-compatible lubricants promotion and distribution, and use; psychosocial support, provision of STI treatment and HTS (2–4 times a year) at DICs [drop-in centres], friendly health facilities, or outreach to hotspots" (p. 35).

Critical enablers

Two thirds (21) of the NSPs that included interventions for people who inject drugs made recommendations on critical enablers. The most common of these, mentioned by 16 NSPs, was that health services be made available, accessible and acceptable to people who inject drugs. With the exception of violence monitoring activities, which were not included in any NSP, each category of critical enabler interventions was included in only a small number of NSPs. The Côte d'Ivoire NSP recommended legal protective measures for people living with HIV that respect the rights of key populations, including sex workers, men who have sex with men, people who inject drugs and people in prisons, so that these populations could benefit more completely from the HIV response. The South Sudan NSP framed HIV interventions as a universal right:

> HIV transmission is positively correlated with lack of respect for human rights. This strategic plan upholds a position of providing services as rights to the population in need. In pursuit of this principle, the plan has put in place interventions targeting populations engaged in social behaviours that may at times be regarded as not entirely formal, immoral or even criminal or illegal (such as sex workers and their clients, drug abusers). (p. 58).

Seven NSPs mentioned that criminal laws make it more difficult for key populations, including people who inject drugs, to access services.

PEOPLE IN PRISONS AND OTHER CLOSED SETTINGS

REPRESENTATION OF PEOPLE IN PRISONS AND OTHER CLOSED SETTINGS

The great majority of the NSPs (38 of 45) addressed people in prisons or other closed settings. While this population is included in some NSPs as one of the key populations, other NSPs list them as a vulnerable group.

There is no explicit discussion of the intersection of the prison population with other key or vulnerable populations. The Zimbabwean NSP is one of the few that explicitly mentioned women in prison. There rarely was discussion of the specific risks that people in prison face. An exception is the NSP of Mauritius, which stated that prison inmates, like sex workers, men having sex with men and transgender people, are often incapable of negotiating condom use. In addition, the NSP stated that these populations are less likely to report cases of violence because of a lack of awareness of their rights and fear of recrimination.

There is no explicit discussion of the intersection of the prison population with other key or vulnerable populations.

HIV EPIDEMIOLOGY AMONG PEOPLE IN PRISONS AND OTHER CLOSED SETTINGS

About two fifths of NSPs included a measure of prevalence among people in prisons and other closed settings. A small minority of NSPs included a measure of individual risk or an estimate of the population size. No NSP reported a measure of incidence or attributable risk.

PLANNED TARGETED INTERVENTIONS FOR PEOPLE IN PRISONS AND OTHER CLOSED SETTINGS

Of the 38 NSPs that mentioned people in prisons and other closed settings, 36 included intervention plans for people in prisons and other closed settings. These plans are summarized in the text below and in Table 6.

HIV prevention

Of the 36 NSPs that mentioned interventions for people in prisons and other closed settings, three quarters (27) made specific plans to extend services to this population for prevention of sexual transmission of HIV. All but one of these included condom programming, but only seven included condom-compatible lubricants. For example, the Malawi NSP planned routine testing among prisoners and to renew focus on provider-initiated testing and counselling. The Namibia NSP planned a scale-up of HIV interventions in prisons: "While there are limited programs in prisons currently, scaling up interventions in the correctional services has been limited by the lack of a clear national policy on HIV and AIDS in prisons. It is necessary to scale up the provision of specific HIV prevention interventions within prisons and the establishment of a follow up programme for inmates when they are released from prisons into the general community" (p. 35). The Sao Tome NSP set out a combination of interventions in prisons that included advocacy to improve response to HIV in prisons; reinforcement of skills of workers in prisons; peer education for prisoners; provisions of condoms; campaigns to promote testing; and activities to raise awareness of HIV in prisons.

NSPs for Côte d'Ivoire, Eritrea, Kenya and South Africa included PrEP for this key population. In Kenya PrEP was recommended for all "vulnerable populations". These included people in prisons and other closed settings. Similarly, the NSP for Eritrea included "interventions directed at groups especially susceptible to high transmission such as female sex workers (FSW) and their clients, truck drivers, prisoners, and sero-discordant couples (SDC), in particular with treatment as prevention and pre-exposure prophylaxis as prevention as a new approach to be added to the behavioral and other supportive interventions" (p. xi).

Table 6. Targeted interventions for people in prisons and other closed settings

	HIV prevention					Harm reduction				HIV testing					HIV treatment				Sexual and repro-ductive health			Critical enablers								
	Condoms	Lubricants	PrEP	PEP	Any prevention	Needle and syringe	Opioid substitution	Naloxone	Any harm reduction	Provider-initiated testing	Community-based testing	Lay provider testing	Self testing	Assisted partner notification	Any HIV testing	Equitable ART	Access and adherence	PMTCT	Any HIV treatment	STI screening and treatment	Antenatal care	Any sex and repro health	Review laws – behaviour	Review laws – services	Train HCW	Train officers	Engage stakeholders	Health services	Community empowerment	Violence prevention	Violence monitoring	Any critical enabler
Algeria (1)	■				■					■	■				■	■	■		■	■		■	■		■			■	■			■
Angola (2)																																
Benin (3)	■				■										■	■	■		■													
Botswana (4)																																
Burkina Faso (5)															■																	
Burundi (6)										■	■				■										■		■	■	■			■
Cape Verde (7)	■				■										■	■			■													
Cameroon (8)	■				■										■					■		■				■		■	■			■
Central African Republic (9)	■				■										■																	
Chad (10)	■				■										■					■		■					■	■				■
Comoros (11)																																
Congo (12)	■				■										■					■		■					■	■				■
Côte d'Ivoire (13)			■	■	■					■	■		■		■												■		■	■		■
Democratic Republic of the Congo (14)																																
Eritrea (15)	■	■	■		■					■					■	■			■				■			■			■	■		■
Ethiopia (16)										■					■					■		■										
Gambia (17)															■					■		■										
Ghana (18)	■	■			■						■				■					■		■										
Guinea (19)															■									■				■	■			■
Guinea-Bissau (20)	■				■																											
Kenya (21)	■	■	■		■	■	■		■						■		■		■	■		■	■	■	■	■	■	■		■		■
Lesotho (22)	■	■			■					■	■				■	■			■	■		■										
Liberia (23)																																
Madagascar (24)	■				■																											
Malawi (25)										■					■																	
Mali (26)																																
Mauritania (27)	■				■										■					■		■										
Mauritius (28)	■				■		■		■																							
Mozambique (29)	■	■			■																											
Namibia (30)															■					■		■										
Niger (31)	■				■						■				■										■		■	■	■			■
Nigeria (32)																																
Rwanda (33)	■				■																											
Sao Tome and Principe (34)	■				■										■																	
Senegal (35)																																
Seychelles (36)						■	■		■																							
Sierra Leone (37)	■	■			■										■		■		■								■	■	■	■		■
South Africa (38)	■		■		■														■	■		■						■		■		■
South Sudan (39)																																
Swaziland (40)																	■		■	■		■			■		■	■				■
Togo (41)	■	■			■																											
Uganda (42)	■				■										■	■	■		■	■		■		■			■	■				■
United Republic of Tanzania (43)	■				■						■				■	■	■		■	■		■		■	■		■	■				■
Zambia (44)	■				■					■	■		■		■	■	■		■					■			■	■				■
Zimbabwe (45)	■				■										■	■		■	■	■	■	■	■	■			■	■				■
Total	26	7	4	1	27	2	3	0	3	8	8	0	2	0	27	9	8	1	12	16	1	16	4	6	6	3	12	15	8	5	0	17

Notes: Interventions are described in Panel 1.
Numbers in parentheses after country names refer to the list of NSPs at the back of this publication.

Harm reduction

The only NSPs to include harm reduction services for people in prisons and other closed settings were those of Kenya, Mauritius and Seychelles. All three mentioned opioid substitution therapy. For example, the NSP for Mauritius included methadone substitution therapy for female prison inmates as an effort to expand services that accommodate women across prison facilities. The Kenya and Seychelles NSPs also made mention of needle and syringe programmes.

HIV testing

Three quarters (27) of the NSPs that mentioned interventions for people in prisons and other closed settings included targeted HIV testing for this group. For example, the Togo NSP set a target for 2020 that 90% of prisoners will know methods of prevention and will have had an HIV test in the preceding 12 months and know their HIV status. A minority of NSPs included specific modalities for HIV testing. The Malawi NSP planned to pilot-test a combination outreach and provider-initiated testing and counselling model for HIV case identification and enrolment in care for prisoners.

HIV care and treatment

One quarter (9) of NSPs that included interventions for people in prisons and other closed settings called for this group to have equitable access to antiretroviral therapy. Only the NSP for Zimbabwe mentioned the need to ensure that pregnant women in prisons and other closed settings have equitable access to PMTCT services. As noted below, the South Africa NSP explained the role of the government in ensuring that prison inmates have access to HIV care and treatment.

Sexual and reproductive health

Close to half (16) of NSPs that mentioned interventions for people in prisons and other closed settings recommended routine screening, diagnosis and/or treatment of sexually transmitted infections among this group. The Mali NSP, for instance, aimed for 75% of key populations and transient populations, including prisoners, to have access to HIV and STI prevention, including condoms, testing and treatment. The South African NSP applied not only to prisoners but also to prison staff: "The Department of Correctional Services must ensure the provision of appropriate prevention and treatment services, including HIV, STI and TB screening, prompt treatment of all inmates and correctional services staff, ensuring continuum of care through proper referrals … " (p. 48).

Critical enablers

Nearly half (17) of NSPs that included interventions for people in prisons and other closed settings made recommendations on critical enablers. No NSP mentioned violence monitoring activities. The other categories of critical enabler interventions each appeared in a small number of NSPs.

SUMMARY AND DISCUSSION

SUMMARY OF FINDINGS

Key populations and related terms

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.

Aspects of WHO's definition of "key populations" – populations at higher HIV risk facing social and legal challenges that increase vulnerability – were usually incorporated into NSPs, although sometimes using alternative terms. Key populations were sometimes identified in NSPs as marginalized populations, most-at-risk populations, priority populations and vulnerable populations. Sometimes these terms were used interchangeably, and sometimes they were used within the same NSP to name distinct groups of populations. For example, in some NSPs men who have sex with men were included in *key populations* and prisoners were included in *vulnerable populations*.

Key populations, as defined by WHO, were sometimes grouped with other populations that are disproportionately affected by the HIV epidemic. Consequently, the particular social and legal circumstances that structure HIV risk and access to HIV services for key populations were not always acknowledged. When men who have sex with men, people in prisons and other closed setting, people who inject drugs, sex workers and transgender people were included in long lists of populations that do not face similar legal challenges or stigma, another problem arose. Many NSPs articulated intervention plans in terms of the overall key population category. In our analysis of these NSPs, we could not distinguish those that had meaningful intentions to tailor interventions to each of the populations included in the key population category from those that included a particular population only nominally. The more populations included in the category of key populations, the less informative that category became.

Representation of key populations

In the vast majority of NSPs, populations included in the definition for key populations were said to face an elevated risk and/or burden of HIV. Sometimes this was attributed to the impact of stigma and discrimination on vulnerability and sometimes to the impact of stigma and discrimination on access to HIV prevention, testing and treatment services. Some NSPs pointed simply to risky sexual behaviour as an explanation for elevated HIV risk.

Inclusion of epidemiological information

Almost all NSPs included information about the epidemiology of HIV among key populations. Prevalence of HIV was most often presented, and most frequently prevalence among sex workers (in about two thirds of the NSPs). Prevalence among men who have sex with men, people in prison and other closed settings and people who inject drugs was successively less frequently reported. Prevalence among transgender persons was reported in only one NSP. HIV incidence in key populations – a difficult parameter to assess – was rarely reported. When incidence was reported, it most often concerned sex workers or men who have sex with men. Individual risk factors for HIV infection were reported less frequently than prevalence but more frequently than incidence. Attributable risk, population size estimates and structural risk factors for key populations were rarely mentioned.

Inclusion of the WHO recommendations for key populations

All but two NSPs included at least one WHO-recommended intervention addressing at least one WHO-defined key population (Table 7). The two exceptions were the NSPs for Angola and Botswana. Among the rest of the NSPs, the recommendations of the WHO consolidated guidelines for key populations were unevenly integrated. NSPs were most likely to include key population-targeted interventions related to HIV prevention and HIV testing. They were least likely to include targeted interventions related to HIV treatment and harm reduction.

Table 7. Summary of interventions for key populations mentioned in natonal strategic plans

	Any mention of HIV prevention						Any mention of harm reduction						Any mention of HIV testing						Any mention of HIV treatment						Any mention of sexual and reproductive health						Any mention of critical enablers					
	SW	MSM	TG	PWID	PRIS	Any key population	SW	MSM	TG	PWID	PRIS	Any key population	SW	MSM	TG	PWID	PRIS	Any key population	SW	MSM	TG	PWID	PRIS	Any key population	SW	MSM	TG	PWID	PRIS	Any key population	SW	MSM	TG	PWID	PRIS	Any key population
Algeria	■	■		■	■	■				■		■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■
Angola																																				
Benin	■	■		■	■	■	■					■	■	■		■	■	■	■	■		■	■	■												
Botswana																																				
Burkina Faso	■	■		■		■				■		■	■	■		■	■	■												■	■		■		■
Burundi		■				■							■	■		■	■	■	■	■				■	■	■				■	■	■		■	■	■
Cape Verde	■	■		■	■	■							■	■		■	■	■	■	■		■	■	■												
Cameroon	■	■		■	■	■							■	■		■	■	■							■	■		■	■	■	■	■		■	■	■
Central African Republic	■	■			■	■							■	■			■	■							■	■				■						
Chad	■	■			■	■							■	■			■	■							■	■			■	■	■	■			■	■
Comoros	■					■																														
Congo	■	■			■	■							■	■			■	■							■	■			■	■	■	■			■	■
Côte d'Ivoire	■	■		■	■	■							■	■		■	■	■												■	■		■	■	■
Democratic Republic of the Congo	■	■		■		■							■	■		■		■							■	■		■		■	■	■		■		■
Eritrea	■				■	■				■		■	■				■	■	■				■	■						■				■	■
Ethiopia	■					■							■				■	■							■				■	■						
Gambia													■			■	■	■							■				■	■	■				■
Ghana	■	■		■	■	■							■	■		■	■	■		■				■	■	■		■	■	■	■	■		■	■	■
Guinea	■	■		■		■				■		■	■	■		■	■	■												■	■		■	■	■
Guinea-Bissau	■	■			■	■							■	■				■												■	■				■
Kenya	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■
Lesotho	■	■			■	■							■	■			■	■	■	■			■	■	■	■			■	■	■	■				■
Liberia	■	■		■		■							■	■		■		■							■	■		■		■	■	■		■		■
Madagascar	■	■		■	■	■				■		■																		■	■		■		■
Malawi	■	■				■							■	■			■	■							■	■				■	■				■
Mali	■	■		■		■				■		■	■	■		■		■	■			■		■						■	■		■		■
Mauritania	■	■			■	■							■	■			■	■							■	■			■	■						
Mauritius	■	■	■	■	■	■	■			■	■	■				■		■							■					■	■	■	■	■		■
Mozambique	■	■		■	■	■																														
Namibia	■	■				■							■	■		■	■	■							■	■		■	■	■						
Niger	■	■			■	■							■	■			■	■													■	■			■	■
Nigeria	■	■		■		■				■		■																			■	■		■		■
Rwanda	■	■		■	■	■							■	■				■	■	■				■	■	■				■	■	■				■
Sao Tome and Principe	■	■			■	■				■		■	■	■		■	■	■																		
Senegal	■	■		■		■				■		■	■	■		■		■							■	■		■		■	■	■		■		■
Seychelles							■	■		■	■	■	■	■		■		■																		
Sierra Leone	■	■	■	■	■	■							■	■	■	■	■	■	■	■	■	■	■	■							■	■	■	■	■	■
South Africa	■	■	■	■	■	■							■					■							■	■	■	■	■	■	■	■	■	■	■	■
South Sudan	■	■				■				■		■							■	■				■	■	■				■	■	■				■
Swaziland	■	■				■				■		■	■	■		■		■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■
Togo	■	■		■	■	■							■	■		■		■	■	■		■		■							■	■		■		■
Uganda	■	■			■	■							■	■			■	■	■	■			■	■	■	■			■	■	■	■			■	■
United Republic of Tanzania	■	■		■	■	■				■		■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■
Zambia	■	■		■	■	■				■		■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■
Zimbabwe	■	■			■	■				■		■					■	■	■	■			■	■	■	■			■	■	■	■			■	■
Total	40	38	3	23	27	41	4	2	0	17	3	18	37	33	1	24	27	38	17	16	1	10	12	18	26	23	1	12	16	26	33	31	4	21	17	33

Notes: SW – sex workers; MSM – men who have sex with men; TG – transgender people; PWID – people who inject drugs; PRIS – people in prisons and other closed settings.
Numbers in parentheses after country names refer to the list of NSPs at the back of this publication.

Table 1 showed that sex workers were the most widely mentioned key population, followed in order by people in prisons and other closed settings, men who have sex with men, people who inject drugs and transgender people. Table 7 shows that this pattern shifted somewhat when we examined how these populations were addressed in each of the six intervention domains in the WHO guidelines (HIV prevention; harm reduction; HIV testing; HIV treatment; sexual and reproductive health; and critical enablers). Within each domain sex workers were the mostly widely mentioned, followed by men who have sex with men. The exception was the domain of harm reduction where, as could be expected, people who inject drugs were the most widely mentioned.

Extent of community involvement

NSPs often acknowledged the importance of involvement of communities of key populations in addressing the HIV epidemic. This acknowledgement was most often made in relation to sex workers and men who have sex with men. Communities of transgender people, people in prisons and other closed settings and people who inject drugs were rarely mentioned. NSPs attributed different roles to communities of key populations, including contributing to the framing of the national response to HIV, monitoring policies, conducting advocacy and ensuring accountability. Some NSPs also noted that communities of key populations have an instrumental role in promoting uptake of HIV services and monitoring the HIV response, particularly because of the barriers faced by key populations. As a result, some NSPs expressed the need to strengthen links with community organizations, the need to strengthen community organizations themselves and the need to engage in community empowerment activities.

DISCUSSION

A major strength of the reviewed NSPs is that all mentioned at least one key population and that nearly all included interventions for one or more key populations. All but two plans include strategies to address HIV in sex workers. The majority also include interventions for men who have sex with men, people who inject drugs and people in prisons and other closed settings. Innovative strategies such as PrEP, self-testing and assisted partner notification are included in some plans, with good opportunities for these relatively new WHO recommendations to become part of future strategic plans.

A major strength is that nearly all NSPs included interventions for one or more key populations. Gaps remain, however.

There are still gaps in programming of HIV services for key populations as measured against WHO recommendations. The gaps are particularly evident for transgender people, people who inject drugs and people in prisons and other closed settings. Overall, there is little specific attention to young members of key populations. Included interventions for key populations tend to focus on HIV prevention and HIV testing services. Descriptions of prevention services lack detail or specificity regarding how to tailor combinations of interventions to address the particular needs of individuals.

Seventeen countries refer to harm reduction for people who inject drugs, 16 of them planning needle and syringe programmes, eight mentioning opioid substitution therapy and two including naloxone distribution. In countries where there is no evidence of injecting drug use, this lack of mention may be appropriate. However, harm reduction is highly effective in preventing HIV transmission in people who inject drugs, and yet these interventions are not consistently included in the strategic plans of countries in the African Region that have evidence of injecting drug use.

Aside from prevention and testing, plans pay limited attention to providing treatment services friendly to key populations or to linking people who test negative to further prevention services (condom programming, PrEP, harm reduction) or linking people who test positive to treatment. Also, there is limited attention paid to services not directly related to HIV care or treatment, such as antenatal care.

Few national strategic plans provide comprehensive data for all key population groups on HIV prevalence, incidence or population size. Some NSPs identify lack of data as a problem. In other cases available data are overlooked or omitted.

Most national strategic plans (42) mention people in prisons and other closed settings, and 27 present specific plans to extend services for prevention of sexual transmission of HIV to this population. Overall, few countries pay attention to continuity of care for people on treatment. Interruption of treatment when people move between the community and prisons as well as within prisons is a major concern.

Limitations of this review

This review faced a number of limitations. These limitations are important to consider when interpreting the findings presented here.

For one, the planning periods of the reviewed national strategic plans vary. In fact, some were no longer current at the time of writing and others coming to an end.

Also, assessment of whether WHO recommendations for key populations were included was not always straightforward. Sometimes the information needed was not explicitly presented. In other cases lack of detail prevented clear judgments. It also was not always clear which intervention was proposed for which population, as many plans listed interventions only for key populations generally.

It is possible that national strategic plans do not reflect the HIV programming that is being implemented. There might be more programming underway than is reported, but, conversely, some intentions articulated in the national strategic plan might not be reflected in actual programming.

Also, WHO recommended some interventions, such as PrEP, HIV self-testing and naloxone distribution to manage opioid overdose, after some of the national strategic plans were developed. This makes analysis of the inclusion of these interventions problematic. Further, the WHO comprehensive package may not be relevant in all settings. Often, a standard package of services based on evidence, utilizing WHO guidance and developed in consultation with all partners in country will be more appropriate and feasible.

RECOMMENDATIONS

Review of these 45 NSPs a snapshot of how key populations are considered in the African Region. While there are some limitations to the methodology and results, as described above, we can deduce some important messages from this exercise:

Coverage

- Advocacy at global and national levels for **inclusion of key populations** in the national HIV responses needs to continue. The findings of this review can be disseminated to help support that inclusion.
- Countries developing **NSPs** need to include key populations. There may be other populations disproportionately affected by HIV and so deserving attention. Still, the five key populations defined by WHO and UN partners deserve particular and specific attention. These populations face structural barriers to services that compound their risk exposure – barriers such as laws that criminalize their behaviour, stigma, discrimination and violence.
- In order to improve global monitoring of the HIV epidemic and response, it is important that countries consistently follow and use the WHO's terminology for key populations.
- Plans need to specifically consider **young people in key populations** and their particular needs.
- National plans should recognize and accommodate **diversity within key populations**, particularly among sex workers and transgender people.

Interventions

- NSPs should incorporate the **defined and evidence-based package of interventions** for key populations, including interventions that foster an enabling environment tailored to the national context.
- **Involving key population communities** in service delivery will increase the reach and effectiveness of prevention, testing, treatment and care. Lay providers can be members of key populations who take on important aspects of service delivery and thus increase accessibility. National programmes can establish the roles of lay providers in serving key populations.

- **Access and adherence to HIV treatment** can be particular problems for members of key populations. Strategic plans should specify how programmes will address these issues, which include treatment interruption due to incarceration or migration.

- Efforts to strengthen **strategic information systems** should explicitly address strategic information for key populations and schedule periodic national assessments of the implementation of key population interventions.

Structural barriers

- In addition to health interventions, NSPs need to review structural barriers relevant to the country and include the critical enablers to address them. WHO can support countries' activities to reduce stigma and discrimination in the health sector, mainly through training of health-care workers. Other UN agencies such as UNDP and UNAIDS can support national reviews of laws and regulations that impede an effective public health response to HIV.

LIST OF NATIONAL STRATEGIC PLANS

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2. **Angola.** National strategy plan on HIV/AIDS 2003–2008. Government of Angola; 2003.

3. **Benin.** Plan stratégique national de lutte contre le VIH/SIDA et les IST 2015–2017. Comité National de Lutte Contre le Sida; 2014.

4. **Botswana.** The second Botswana national strategic framework for HIV and AIDS 2010–2016. National AIDS Coordinating Agency, Ministry of State President, Government of Botswana; 2009.

5. **Burkina Faso.** Plan d'extension du cadre stratégique de lutte contre le VIH, le SIDA et les IST (CSLS): Document d'orientation de la réponse au VIH 2015–2017. Secrétariat Permanent, Conseil National De Lutte Contre Le Sida et les IST, Présidence Du Faso; 2014.

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7. **Cabo Verde.** Plano estratégico nacional de luta contra a SIDA (2011–2015). Comité de Coordenação do Combate à SIDA, Cabo Verde; 2010.

8. **Cameroon.** Plan stratégique national de lutte contre le VIH, le SIDA et les IST 2014–2017. Comité National de Lutte contre le Sida, Cameroun; 2013.

9. **Central African Republic.** Plan stratégique national de lutte contre le VIH et le SIDA 2016–2020. Comité National de Lutte Contre Le Sida (CNLS), Présidence de la République, République Centrafricaine; 2015.

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13. **Côte d'Ivoire.** Plan stratégique national 2016–2020: de lutte contre l'infection à VIH, le SIDA et les infections sexuellement transmissibles. Programme National de Lutte Contre le SIDA, Ministère de la Sante et de la Lutte Contre le SIDA, République de Côte d'Ivoire; 2016.

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15. **Eritrea.** The fifth Eritrea national strategic plan on HIV and AIDS/STI (ENASP V) 2017–2021: Towards universal access & zero new infections and AIDS deaths. Ministry of Health, The State of Eritrea; 2017.

16. **Ethiopia.** HIV/AIDS strategic plan: 2015–2020 in an investment case approach. Federal HIV/AIDS Prevention and Control Office, Addis Ababa, Ethiopia; 2014.

17. **Gambia.** National policy guidelines on HIV and AIDS 2014–2020. National AIDS Council, Government of the Republic of The Gambia.

18. **Ghana.** National HIV & AIDS strategic plan 2016–2020. Ghana AIDS Commission, Office of the President, Republic of Ghana; 2016.

19. **Guinea.** Cadre stratégique national de lutte contre les IST/VIH/SIDA 2013–2017. Comité National de Lutte contre le Sida, République de Guinée.

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22. **Lesotho.** National HIV and AIDS Strategic Plan 2011/12–2017/18. The Kingdom of Lesotho; 2015.

23. **Liberia.** National HIV & AIDS strategic plan 2015–2020. Republic of Liberia; 2014.

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37. **Sierra Leone.** National strategic plan on HIV/AIDS 2016–2020: Rapid response initiative to ending HIV as a public health and development problem. National HIV/AIDS Secretariat, Republic of Sierra Leone; 2015.

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