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MINIMUM STANDARDS FOR THE PROTECTION OF THE SEXUAL AND REPRODUCTIVE HEALTH OF KEY POPULATIONS IN THE SADC REGION

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ACKNOWLEDGEMENT

Over the last decade, the SADC Parliamentary Forum has been involved in several initiatives which have heightened the protection afforded to Key Populations (KPs) in the context of HIV. Within the paradigm of inter-parliamentary cooperation, the Forum has consistently worked with strategic partners to develop standard-setting normative content that can serve as a yardstick to national Parliaments as they buttress their legal and policy frameworks on HIV/AIDS. Whilst much territory has been gained in access to Anti-Retroviral Treatment and for ensuring that PLHIV know their status, the stark truth remains that the SADC region is still known as the epicentre of the HIV/AIDS pandemic with over 20 Million PLHIV in Eastern and Southern Africa alone, and about one-third of this number not accessing proper treatment. Cognisant of this hard reality, the Forum has thus embarked in the development of Minimum Standards for Key Populations in the SADC region through an inclusive and participatory process that involved Parliamentarians (MPs), Civil Society Organisations and other regional partners.

The development of the Minimum Standards occurred on the bedrock of a strong evidential basis, as highlighted in the Situational Analysis, and this served to facilitate the decision-making process leading to their adoption by the 44th Plenary Assembly of the Forum held from the 26th November to the 10th December 2018 in Maputo, Mozambique. The Minimum Standards provide benchmarks relating to different governance areas that directly concern the protection of KPs, and Member Parliaments are thus encouraged to consider and implement the Standards through parliamentary interventions at the domestic level in consultation with the relevant HIV authorities and CSOs. Without doubt, the domestication of the Minimum Standards within country contexts will go a long way in heightening the national HIV responses and bringing Southern Africa closer to fulfilling its commitments such as the 90-90-90 targets and the Sustainable Development Goals.

In the development of the Minimum Standards, I wish to thank the MPs of the Forum and all the stakeholders who have constructively conveyed their input and views for the finalisation of the document. This consultative process in itself demonstrated the earnest maturity and unwavering sense of commitment by diverse stakeholders in joining hands for the elimination of HIV in the SADC region. In addition, I wish to thank the UNDP and UNFPA for their technical and financial contributions. Furthermore, I acknowledge the Embassy of Sweden for the Swedish-funded SRHR, HIV and AIDS Governance Project that facilitated the reflections on this important topic.

The Minimum standards were compiled by Mr Russell Armstrong with guidance from Mr Innocent Modisaotsile of UNFPA and Mr Mesfin Getahun of UNDP. I wish to express my sincere appreciation to the team.

With these words, we are confident that the eradication of HIV is now within reach and the Forum with its strong partnership base will continue to work tirelessly to turn this goal into reality.

Ms Boemo Sekgoma
Acting Secretary General

SADC Parliamentary Forum

ACRONYMS

ACHPR	African Commission on Human and People's Rights
AIDS	Acquired immune deficiency syndrome
ARASA	AIDS Rights Alliance for Southern Africa
ART	Antiretroviral therapy
AU	African Union
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
PLHIV	People living with HIV
PWID	People who inject drugs
SADC	Southern African Development Community
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNOHCHR	United Nations Office of the High Commissioner for Human Rights
WHO	World Health Organization

DEFINITIONS OF KEY TERMS AND CONCEPTS

Adolescents: Persons aged 10 to 17 years. Adolescents are not a homogeneous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age.[1]

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

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

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

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

Member State: Member state is defined in the Treaty of the Southern African Development Community (SADC) as a member of said community.

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

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

[1] The definitions in this section, except where otherwise indicated, have been adapted from the World Health Organisation (WHO). Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (WHO, 2014).

[2] CEDAW, General Recommendation No. 19 (1992), para 6.

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

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

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

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

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

Young key populations: This term refers to individuals between the ages of 18 and 24 years who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviours that increase their vulnerability to HIV. For the purposes of this strategy, key populations include: 1) men who have sex with men; 2) people in prisons; 3) people who use drugs; 4) sex workers; and 5) transgender people.

Young people: This term refers to individuals between the ages of 18 and 24 years. Young people are not a homogeneous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age.

1. BACKGROUND

According to the most recent analysis, in 2017, across the East and Southern African region there were 42% fewer AIDS-related deaths than in 2010, and 30% fewer new HIV infections (UNAIDS, 2018). However, the size of the epidemic remains large and continues to grow with an estimated 800,000 new HIV infections in 2017 along with 380,000 AIDS-related deaths. HIV infections in 11 of the 15 member states of SADC amounted to 643,700 or 84% of all newly infected adults and children in 2017 in the East and Southern African region.

At the same time, however, progress continued to be made to diagnose more people living with HIV (PLHIV), to enrol them on antiretroviral treatment (ART), and to support them to the point of reaching and sustaining viral suppression (UNAIDS, 2018). By 2017, of the almost 20 million PLHIV of all ages in the East and Southern African region, 81% were estimated to know their status; 13 million, or 66%, were on antiretroviral treatment (ART); and, 52% had achieved viral suppression. With regard to prevention of mother-to-child transmission of HIV, an estimated 93% of pregnant women living with HIV were receiving ART in 2017, thus lowering the rate of vertical transmission to below 10%.

Yet few, if any, countries in SADC will meet the 2020 goal of a 75% reduction in new HIV infections from their 2010 baselines (SADC, 2018). Across the East and Southern African region, meeting the fast-track targets will require an additional 1.7 million PLHIV of all ages to be diagnosed, 2.9 million to be enrolled on ART, and 4 million to achieve viral suppression (UNAIDS, 2018). Strong, collective will and sustained investments in people and systems will be paramount, as well as full realization of the 'leave no one behind' commitment that is now central to national, regional, continental and global HIV responses. This commitment is expressed in the 2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030; the African Union Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030; and the declaration on the Sustainable Development Goals (SDGs), Transforming Our World: The 2030 Agenda for Global Action (United Nations, 2016; African Union, 2016; United Nations, 2015). All member states are signatories to these declarations and commitments.

Across SADC, those 'most left behind' include key populations defined as those individuals and groups which, in addition to having the highest burden of HIV and other diseases, and the least access to HIV programmes that meet their specific needs, face a number of barriers. These include criminalisation and other discriminatory laws and policies; high levels of stigma, discrimination, and physical and sexual violence; and other systematic human rights violations in the form of harassment and abuse by law enforcement agents, including arbitrary arrest and detention, and, in some cases, treatment that amounts to torture as it is defined under national, continental and global standards (WHO, 2017).

These groups generally include gay men and other men who have sex with men (MSM); transgender people; sex workers of all genders (male, female, transgender); people who inject drugs (PWID); and prisoners (WHO, 2017). As a result, they have a significantly higher degree of risk and vulnerability to HIV infection, which was recently estimated at the global level to be 28 times higher for gay men and other MSM than their adult heterosexual peers; 22 times higher for PWID than non-drug-using adults; and, 13 times higher for female and transgender sex workers than for all adult women (UNAIDS, 2018). These differences are indeed significant and have not substantially changed in recent periods.

The SADC community is not unaware of these challenges and there is now a clear commitment across all member states to close the gap for key populations within national HIV responses. To bolster this work, in November 2017, SADC Ministers of Health approved the Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations 2017 to 2020 (SADC, 2017). The strategy calls for, among other actions, swift and comprehensive legal and policy change to prevent and eliminate the enduring high levels of stigma, discrimination, and physical and sexual violence that key populations experience across SADC, which inhibits their access, uptake and retention in HIV and other SRH programmes. The active engagement of parliamentarians and parliamentary processes across all member states is crucial for such change to occur.

The SADC Parliamentary Forum, in collaboration with cooperating partners, has been consistently involved in initiatives aimed towards fortifying the protection of key populations across member states, in the specific context of preventing new HIV infections and AIDS-related deaths for all groups, and, more broadly, for the creation of more just, equal and inclusive societies across the region as called for under the African continent's Agenda 2063 and the Sustainable Development Goals (SDG), especially Goal 3 (ensure healthy lives), Goal 5 (achieve gender equality), Goal 10 (eliminate all inequalities), and Goal 16 (peaceful, inclusive and just societies) (African Union, 2015; UN, 2015). The protection of key populations is strongly grounded in human rights instruments such as the Universal Declaration of Human Rights; the International Covenant on Economic, Social and Cultural Rights; the African Charter on Human and People Rights; the Protocol to the African Charter on the Protection of Women in Africa; and the African Charter on the Rights and Welfare of a Child (AIDS Rights Alliance for Southern Africa [ARASA], 2017; United Nations Office of the High Commissioner for Human Rights [UNOHCHR]; 2015). Reference is also made to the African Commission on Human and People's Rights (ACPHR) Resolutions 275 on Protection against Violence and other Human Rights violations on the Basis of Real or Imputed Sexual Orientation and Gender Identity; the General Comment 4 on Article 5 of the African Charter: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment; and the UN Joint Statement: Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people (ACHPR, 2017; UNOHCHR and others, 2015).

The relevance of protecting key populations is also acknowledged in the SADC Model Law on HIV in Southern Africa (for example Chapter 4 on individuals in prisons), and is alluded to in the Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (SADC 2008, 2016). Furthermore, in accordance with the SADC-sponsored Resolution 60/2 of the Commission on the Status of Women relating to "Women, the girl child, and HIV and AIDS," issues relating to stigmatization and discrimination were identified as well as availability and affordability of HIV treatment, which are live matters for key populations, especially with respect to the implementation and the fulfilment of the human right to health.[3] Moreover, the first-ever Women Parliament held under the auspices of the Forum in Mahé, Seychelles, in July 2017, and the ensuing Mahé Declaration, reiterated the significance of reinforcing legal and policy frameworks of member states in order to holistically address the vulnerabilities of people living with HIV (PLHIV), including key populations.[4]

The development of these minimum standards, then, is a logical next step to deepen the engagement of member states to prevent stigma, discrimination and violence against key populations or any other social group; to address and remove punitive laws, policies and practices that, while infringing on the human rights of key populations also negatively affect that ability of member states to manage their HIV epidemics; and, finally, to create more enabling environments for the expansion of programmes and services for these groups that, until this point, have been significantly 'left behind' at member state and regional levels.

[3] See: https://www.sadc.int/files/2214/3878/4046/SADC_Technical_Meeting_to_review_the_SADC_sponsored_United_Nations_Resolution_on_Women_-_Full_Report.pdf.
[4] See: http://www.arasa.info/files/1615/1075/0690/Mahe_Declaration_by_RWPC_Women_Parliament_1_1.pdf.

2. RATIONALE

At the 42nd and 43rd Plenary Assemblies of the SADC Parliamentary Forum there was substantive debate about the situation of key populations in the region and on the many ongoing barriers to the scaling-up of comprehensive HIV and other SRH programmes for these groups. Such programmes are essential for the efforts of member states and the region as a whole to reduce new HIV infections and AIDS-related deaths. Moreover, the organs of the Forum have acknowledged that while most SADC member states have committed to achieve the 90-90-90 targets for 2020 in order to end AIDS by 2030, the protection of key populations is a necessary requirement for the achievement of this objective.

These decisions were informed by the recommendations of the Human and Social Development and Special Programmes Standing Committee which identified that the protection of key populations was as a common concern across SADC and which called for immediate law and policy reform at different levels of governance. It was further observed that the protection or lack of it for key populations was intricately intertwined with the transmission of HIV and the stalling of progress in the reduction of new infections and AIDS-related deaths in the region.

To this end, it was deemed prudent for the Forum to develop **minimum standards on the Protection of Sexual and Reproductive Health for Key Populations in the SADC Region** which would assist member states in general, and national parliaments in particular, to gauge the efficacy and impact of national policies and legislation to protect key populations and to eliminate the root causes of such widening gaps in national and regional HIV responses.

3. PURPOSE AND SCOPE OF THE MINIMUM STANDARDS

The purpose of the minimum standards is to provide guidance and support for parliamentarians across SADC in their role to make interventions at parliamentary and constituency levels for the protection of the SRH of key populations and for ensuring that all individuals in member states achieve their right to health. The standards have been developed as a central parliamentary and policy tool that will serve as a reliable benchmark for critical reforms relating to such critical measures.

These standards build on, and are linked to, the minimum standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons; the Regional minimum standards and Brand for HIV and other Health Services along the Road Transport Corridors in the SADC Region; and, the minimum standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region (SADC, 2009, 2015a, 2015b).

These minimum standards define essential requirements and opportunities for improving protections for key populations against stigma, discrimination and violence; addressing the negative effects of punitive laws, policies and cultural practices; and ensuring access to relevant information and services for HIV prevention and health promotion. The standards give due regard to the range of country contexts that exist across SADC for improving protections for key populations while, at the same time, clarifying essential obligations of all member states for the protection and promotion of health and human rights for all.

4. GUIDING PRINCIPLES

The minimum standards are meant to be applied according to the following overarching principles which are already widely recognised by member states:

Protection and promotion of human rights for all – All persons have the following fundamental rights guaranteed under international, regional and national laws: right to be free from discrimination; right to equality; right to be free from torture and cruel, inhuman and degrading treatment; right to dignity; right to security of the person; right to information; and, the right, including in prisons and other closed settings, to the highest attainable standard of health.

Healthcare for all – Healthcare providers and institutions must serve all people based on the principles of medical ethics and the right to health. No person should be refused needed healthcare services on the basis of their gender, sexual orientation, gender identity or gender expression, their status as a person who sells sex, or based on past or current substance use, or their status as an inmate or parolee.

Political commitment – High-level political commitment is required to ensure universal access to health services and to remove barriers for key populations. The SADC Secretariat and member states are demonstrating this commitment through the adoption of the Regional Strategy and these corresponding minimum standards. This commitment must be continually strengthened and sustained.

Respect for diversity – Laws, policies and programmes should be inclusive of the diversity of all citizens regardless of gender, sexual orientation, gender identity or gender expression. They should acknowledge, respect and reflect the diversity of experience, sexual orientation, sexual expression, sexual identity and choice of profession among key populations.

Privacy and confidentiality – All health service users, in all their diversity, have the right to privacy and full confidentiality of their health information. Health professionals have a duty to respect the essential human dignity of all persons and to protect the privacy and confidentiality of their patients.

Involvement and participation – Members of key populations should be fully involved in designing and implementing laws, policies and programmes aimed toward improving their health and protecting them from stigma, discrimination and violence.

Do no harm – No members of key population groups must be put at risk of harm as a direct or indirect result of the development and implementation of these minimum standards.

Evidence-based – Laws, policies and programmes should be enacted or developed based on the latest available comprehensive and reliable evidence.

5. PROCESS FOR DEVELOPING MINIMUM STANDARDS

The minimum standards were developed as an initiative of the Standing Committee on Human and Social Development and Special Programmes. The initial stage included a comprehensive desk review on the situation of key populations in SADC, particularly the aspects of stigma and discrimination, violence, punitive laws and policies, and limited access to relevant and appropriate health information and services.

Standing Committee members, other parliamentarians, parliamentary researchers, legislative drafters, regional representatives from key population networks, regional organisations addressing SRH, and technical partners participated in a consultative meeting held in August 2018 to review the findings of the situational assessment and to propose the main components of the minimum standards.

Subsequent to the meeting, a draft of the minimum standards was prepared and circulated for review and comment. The Standing Committee convened again in November 2018, joined again by representatives from key population networks and technical partners, to review and validate the draft minimum standards. Following validation, the minimum standards were presented for adoption at the 44th Plenary Session of the SADC Parliamentary Forum held in December 2018 in Maputo, Mozambique.

6. THE SITUATION OF KEY POPULATIONS IN SADC

Key populations in all member states have rates of HIV prevalence that are significantly higher than adults in the general population (UNAIDS, 2015). For example, HIV prevalence for sex workers reaches as high as 72% in Lesotho, for MSM as high as 27% in South Africa, for PWID as high as 32% in Mauritius, and for prisoners as high as 35% in Swaziland. This situation arises as a result of a number of structural factors that create the increase in the risk and vulnerability to HIV infection and that raise numerous barriers to HIV and other SRH programmes meant to promote their health (UNAIDS, 2018).

Slowing HIV transmission among these groups, through prevention and through improving access to and retention on HIV treatment, is a critical component for all countries to meet fast-track targets for reducing new HIV infections and reaching 90% or more of all people living with HIV with life-saving ART by 2020 (SADC, 2018; UNAIDS, 2018).

Impeding these efforts and driving marginalisation and exclusion of key populations from HIV services are alarmingly high rates of stigma, discrimination and violence, particularly for gay men and other MSM, sex workers of all genders, transgender women and people who inject drugs. These things continue to occur even in member states where same-sex sexual activity or sex work are not criminalised (ARASA, 2016, 2017).

For prisoners, especially young prisoners, prison conditions, which include overcrowding, mixing of juvenile detainees with adults, underfunding and understaffing, gang-related activities, and the complex challenges for prisons authorities in most member states to acknowledge and address sexual activity and drug use in prison settings, compounds HIV risk for these groups and limits the effectiveness of HIV programmes, particularly ART, where they are provided (Aurum Institute, 2018).

Despite that fact that most member states now recognise key populations in their national HIV strategic plans and related documents, the broader legal and policy context is not changing and the commitments to address these challenges that these plans contain are largely not implemented.

Criminalisation is the norm for key populations across SADC with exceptions only in the small number of member states that do not have such punitive laws (ARASA, 2016). However, outside South Africa, no member state has enacted laws or policies to specifically prevent stigma, discrimination and violence against key populations and to ensure access to justice and redress.

Nor have these member states made significant efforts to ensure that broader constitutional and legal protections and processes to address stigma, discrimination and violence against all citizens, and to guarantee access to health services, are claimable and enforceable by key populations themselves (ARASA, 2016).

In spite of these challenges, efforts to respond to and prevent stigma, discrimination and violence are expanding. These are almost exclusively led by civil society entities of which many are led by key populations themselves. There is very little involvement of state-level entities in this work, however, and the programmes run by civil society are frequently not afforded sufficient technical and financial capacity to reach an appropriate level of scale and to maintain this work to the point where it can achieve sustained change.

Parliamentarians across SADC continue to play key roles in state-level HIV responses and more and more are taking up issues for key populations. The support of the SADC Parliamentary Forum, particularly through the SRHR, HIV and AIDS Governance Project, is encouraging more parliamentarians to do this work in their respective countries.

However, parliamentarians continue to encounter a number of barriers and challenges to making progress, particularly at the pace that is needed in order to reach national and regional level goals and targets for their HIV responses. These include a prevailing climate of negative attitudes and beliefs among their peers regarding the legitimacy of key population concerns; the numerous competing priorities parliamentarians face to respond to the needs of their constituents and the risks to themselves and their own political careers for taking up what are still very complex and divisive issues among their constituents.

Despite these challenges, there is now SADC-wide recognition of the serious issues faced by key populations in the region. Largely as a result of the investment priorities of donors (there is almost a total absence of domestic financial commitments to these efforts) HIV programming for key populations is expanding in member states and this is providing opportunities to address structural barriers while at the same time extending needed services.

7. REGIONAL MINIMUM STANDARDS FOR THE PROTECTION OF THE SEXUAL AND REPRODUCTIVE HEALTH OF KEY POPULATIONS IN THE SADC REGION

The minimum standards are set out in the sections that follow:

7.1 Reducing stigma and discrimination

7.1.1 Rationale

Stigma and discrimination against key populations remains at very high levels in all member states, even where, in some cases, there are no criminal laws affecting these groups. Stigma and discrimination occur in families, communities, in health-care services, and in employment, housing and education. Different forms of media also play a role through biased and stigmatising reporting about key populations, and by giving voice to individuals who express discriminatory and negative attitudes, particularly those calling for social rejection and punishment of these groups. All of this creates high levels of fear and intimidation for key populations and, in addition to many other challenges, keeps individuals away from HIV and other health services.

The following standards will guide parliamentarians and member states to reduce stigma and discrimination against key populations, including within health services.

7.1.2 General standards

Constitutional protections against all forms of discrimination are applied in an inclusive and comprehensive manner for all citizens in line with regional and international treaties, conventions and guidelines.

National human rights institutions take an active role in addressing and preventing discrimination against key populations on the basis of gender, sexual orientation, gender identity or expression, choice of occupation as a sex worker, drug use, or status as an inmate or parolee.

National human rights institutions monitor and report on stigma and discrimination against key populations through collaborative partnerships with key population groups, technical partners and communities.

Laws, regulations and codes of practice governing the media prohibit language and reporting that promote or encourage stigma and discrimination against key populations or other vulnerable groups. Mechanisms are in place through regulatory bodies to monitor and enforce relevant provisions.

7.1.3 Preventing discrimination in health services

Laws, regulations and codes of practice for all healthcare providers contain clear and enforceable provisions regarding professionalism, ethics and the avoidance of any forms of stigma and discrimination in the provision of health services.

Training curricula for healthcare professionals contain appropriate content regarding ethics, professionalism and the entitlement of all citizens to receive services based on their health needs.

Patient charters are displayed in health facilities that clearly state the responsibilities and entitlements of all patients and healthcare providers in the provision of health services. Mechanisms are in place to monitor compliance with the charters.

Mechanisms governing the provision of health services, particularly complaints mechanisms, from the facility to the national level, have sufficient technical and operational capacity to respond to and prevent instances of stigma and discrimination against key populations and all other health service users.

Laws, regulations, policies and practices governing privacy and confidentiality for all individuals in healthcare settings address the concerns of key populations, are clear and comprehensive, and are strictly enforced and monitored.

7.1.4 Prevention of stigma and discrimination in other sectors

Laws and policies are adopted or amended to include provisions preventing discrimination in employment, housing, education or social development on the basis of gender, sexual orientation, gender identity or expression, choice of profession, status as a drug user, or status as an inmate or parolee.

7.1.5 Addressing stigma and discrimination in communities

Traditional structures have capacity and become involved in addressing and preventing discrimination against key populations in families and communities.

Local elected officials understand and can advocate for the reduction of stigma and discrimination against key populations.

Religious leaders and religious institutions promote tolerance and acceptance of key populations in communities.

7.1.6 Opportunities for parliamentarians

Parliamentarians, as elected representatives of all constituents, regardless of their status as key populations, have the following responsibilities and opportunities for reducing stigma and discrimination:

- Advocate for ensuring that provisions in national constitutions against all forms of discrimination protect everyone, including on the basis of their gender, sexual orientation, gender identity or expression, choice of occupation, drug use, or status as an inmate or parolee.
- Call for national human rights institutions to actively monitor stigma and discrimination against key populations and to be accountable for taking an active role to protect these groups.
- Raise awareness about and advocate against stigma and discrimination against key populations through public statements at constituency meetings, in national assemblies and through the media.
- Protect key populations from stigma and discrimination by working with local religious and cultural leaders, and other elected officials, to raise awareness about the harm in their communities and their role to take action to prevent them.
- Receive and take action on complaints by members of key populations about stigma and discrimination in healthcare services and in all other public services, especially education, housing and employment.
- Regularly visit healthcare facilities in constituencies to ensure that patient charters are displayed and that healthcare providers and service users understand and uphold them.
- Support members from key populations to use existing structures, such as village health committees, health facility management committees and other similar structures, to raise awareness about their needs and to report instances of stigma and discrimination when they occur.

7.2 Ending violence against key populations

7.2.1 Rationale

Key populations in all member states continue to record alarming rates of physical and sexual violence against them. Law enforcement agents harass and abuse key populations, through arresting and detaining them without following proper procedures and, while in custody, threatening their safety and security, including through verbal, physical and sexual assault. Criminal laws, and negative attitudes and beliefs about key populations encourage violence, much of which is not reported or investigated because individuals fear that their situation will be made worse through discrimination by law enforcement agents and through retribution in communities. Although physical and sexual violence are criminal acts in all member states, and constitutions are meant to protect all citizens against violence and abuse, including while in police custody, individuals from key populations rarely have their rights respected or protected.

The following standards will guide parliamentarians and member states to prevent and eliminate all forms of violence against key populations:

7.2.2 General standards

Constitutional provisions addressing freedom from arbitrary arrest and detention; equal application and benefit of the law; and freedom from cruel, unusual, degrading and inhumane treatment are applied equally to all individuals in all of their diversity.

Criminal provisions regarding physical and sexual assault, regardless of the circumstances of such crimes, are applied fairly and equally for all citizens, irrespective of gender, sexual orientation, gender identity or expression, choice of occupation, status as a drug user, or status as an inmate or parolee.

7.2.3 Eliminating violence and abuse from law enforcement agents

Laws, policies and processes providing for oversight of law enforcement agencies take up as a priority ending police abuses against key populations.

Law enforcement agents in communities are equipped, trained and held accountable for intervening to prevent violence against key populations.

National human rights institutions monitor, report on and intervene to prevent human rights abuses by law enforcement agencies against key populations.

Law enforcement agencies, with the support of key population groups, technical partners and others, have in place policies and programmes for strengthening their capacity to protect individuals from key populations in communities against verbal, physical and sexual violence and abuse.

7.2.4 Violence motivated by stigma and discrimination ('hate crimes')

Laws are enacted or amended to recognise as a criminal offence, subject to specific and appropriate sanctions, public statements in all forms and methods that encourage acts of violence against key populations.

Laws are enacted or amended to recognise as a criminal office, subject to specific and appropriate sanctions, violence that is motivated, committed or encouraged by stigmatising and discriminatory statements, attitudes or beliefs (in addition to those addressing violent assault more generally).

Comprehensive programmes are in place for raising public awareness about the rights and harms associated with stigmatising and discriminatory statements, attitudes or beliefs against any group, including key populations, and for enlisting the support of the general population to prevent or eliminate them.

7.2.5 Preventing and eliminating sexual violence

Laws addressing sexual violence and assault are enacted or amended to categorise sexual violence as a criminal act regardless of gender, sexual orientation, gender identity or expression.

Laws addressing sexual violence and assault recognise all forms of unwanted or non-consensual sexual contact.

Law enforcement agents are equipped, trained and held accountable for responding in a timely, caring and non-discriminatory manner to survivors of sexual violence, regardless of gender, sexual orientation, gender identity or expression, or choice of profession as a sex worker.

Comprehensive programmes are in place in communities to support all survivors of sexual violence without discrimination, and that include enhanced support for justice and redress, as well as for healing and rehabilitation.

Comprehensive public awareness campaigns are in place for the prevention of sexual violence for all, regardless of gender, sexual orientation, gender identity or expression, or choice of profession as a sex worker.

Laws, policies and mechanisms within prison settings are established or strengthened for the prevention and punishment of sexual violence and abuse. Such mechanisms guarantee privacy, confidentiality and safety for survivors when they report such offences and seek medical and psycho-social support as well as legal redress.

Prisons officials and staff are trained and equipped to implement and be accountable for such laws, policies and mechanisms.

7.2.6 Opportunities for parliamentarians

Parliamentarians as elected representatives and public officials have the following responsibilities and opportunities for reducing and ending violence against key populations:

- Raise awareness about violence against key populations in national assemblies and through parliamentary committees, and in constituencies, through public forums and the media, in order to generate public support for stronger measures to prevent and eliminate such criminal acts for the safety and benefit of everyone in communities.
- Participate on police oversight bodies to raise issues of abuses against key populations, to emphasise that they are criminal acts, and to call for strong measures to prevent and end such practices. This includes, where needed, advocating for adequate technical or financial resources to support law enforcement agencies to bring about needed change.
- Work in constituencies to establish and support partnerships between law enforcement agencies, key population groups, healthcare workers, local political leaders, traditional and religious leaders, and other relevant stakeholders for the prevention of all forms of violence and abuse, and for ensuring rapid responses when such things do occur.
- Propose new or amended laws that criminalise public statements or incitements to violence against key populations as well as perpetrators of violence motivated by stigma and discrimination.
- Propose new or amended laws to ensure that criminal provisions against verbal, physical or sexual assault protect everyone, including key populations.
- Call for national human rights institutions to monitor and report on violence against key populations and to be actively engaged in holding to account law enforcement agencies, the judiciary and other stakeholders for preventing and ending such criminal acts.

7.3 Monitoring and reforming laws and policies

7.3.1 Rationale

Enabling laws and policies are critical for the protection of key populations and for supporting the expansion of needed HIV and other SRH services. All member states criminalise behaviours in respect of at least one or more key population groups. Such laws are frequently misinterpreted or misapplied to the extent that individuals themselves are criminalised, such as sex workers or gay men and other MSM, whether or not they engage in such behaviours.

Criminalisation fuels verbal, emotional, physical and sexual violence and abuse against key populations and creates an atmosphere where such abusers feel that they are immune to punishment or censure. Criminalisation also leads to stigma and discrimination in health services and drives key populations away from HIV and other services for fear of having their confidentiality violated and of being reported to the police. In member states where there are no criminal statues against certain key population groups there are also few if any protective laws or policies protecting and promoting their legal and human rights.

With regard to policies, the situation is improving with many member states now recognising in their national HIV and SRH policies the presence of key populations and the need to put in place specific measures to protect them and to guarantee access to services. While this is a positive development, without substantive legal reform challenges will remain for effective implementation of these policies and for effective mechanisms for individuals to access the protections and benefits they are meant to afford.

The following standards will guide parliamentarians and member states to reform criminal laws and to enact new laws and policies to protect key populations and to support their access to HIV and other SRH services:

7.3.2 General standards

Processes are in place involving a range of stakeholders, including parliamentarians, to review and amend all laws and policies addressing key populations that have negative impacts on their SRH, including for reducing new HIV infections and AIDS-related deaths.

Where barriers and negative effects are identified, plans are put in place to amend or repeal the relevant laws or policies and to replace them with suitable instruments for the promotion and protection of the health and human rights of key populations.

7.3.3 Laws

Laws which criminalise consensual sexual contact between adults are reviewed, amended or repealed. This includes same-sex sexual activity and sex work.

Laws addressing illicit drug use are reviewed and amended, where necessary, in order to reduce the personal and social harms arising from overly broad approaches.

Existing laws are strengthened, or new laws enacted, which include anti-discriminatory clauses on the basis of gender, sexual orientation, gender identity or expression. Such laws also establish mechanisms by which individuals experiencing discrimination on these grounds can bring claims for investigation and redress.

Programmes are put in place to raise awareness of human rights, protective laws, and mechanisms for access to justice and redress among key populations in communities so that individuals are knowledgeable about them and able to benefit from them.

Laws are reviewed and amended, where necessary, so that they adequately distinguish between sex work and human trafficking on the one hand, and sex work and commercial exploitation of children on the other. These phenomena are distinct and should not be conflated in either law or policy.

Laws concerning petty offences (public nuisance, public decency, loitering, vagabonding, and others) which are used to disproportionately harass or detain individuals from key populations in communities are reviewed, amended or repealed.[5]

Laws, policies and procedures for changing gender markers, in national registries and on identity documents, are applied in a non-discriminatory and enabling manner.

Programmes are in place to support equal access for key populations to mechanisms for justice and redress, such as legal information and referrals; legal advice and representation; alternative forms of dispute resolution; or traditional legal systems.

Training programmes are in place for judicial officers, from the magistrate to the senior levels, on the role of the judiciary in protecting and upholding the health and human rights of key populations.

Law and policy frameworks governing the judiciary include up-to-date content on human rights, aligned with regional, continental and international agreements, covenants and guidance on issues of diversity and inclusivity, including where such issues relate to public health.

National human rights institutions offer the same protections to key populations as they do to all individuals. In addition, relevant staff in these institutions are competent, accessible and available to individuals from key populations when they are in need of assistance or protection.

7.3.4 Policies

Policies related to SRH, including HIV, are protective of key populations, promote their health, and are non-discriminatory with regard to gender, gender identity and expression, sexual orientation, choice of occupation, status as a drug user, or status as an inmate or parolee.

National strategic plans for HIV, SRHR and the health sector recognise key populations and contain specific results and strategies for improving their protection and for promoting their health.

Drug policies promote harm reduction, particularly needle and syringe exchange programmes, and the introduction of opioid substitution therapy where relevant and feasible.

Policies addressing labour and small business recognise sex work as work such that sex workers have same responsibilities and entitlements as other workers or business owners.

Policies regarding social welfare do not discriminate, on the basis of sexual orientation, gender, gender identity or expression, or choice of profession, in the adjudication of family and child welfare matters, including for child protection. In particular, children of sex workers should not be deemed in need of protective care purely on the basis of their parents' occupation.

Policies regarding the prevention of gender-based violence are inclusive of all genders and of sex workers.

Policies governing educational institutions are inclusive, protective and non-discriminatory towards all learners, irrespective of gender identity and expression, and sexual orientation.

Educational curricula, in age-appropriate formats and methods, promote inclusivity, respect for diversity, and non-discrimination.

Policies are in place for all places of detention that protect individuals from stigma, discrimination and verbal, physical or sexual violence based on gender identity and expression, sexual orientation, or prior status as a sex worker or drug user. Such policies include specific and appropriate measures for the protection of transgender people, and young detainees who are members of key population groups.

[5] In conducting such reviews, member states should take into account the African Union's Draft Guidelines on the Declassification and Decriminalisation of Petty Offences (2017). Available: http://www.achpr.org/files/news/2017/03/d283/zero_draft_principles_on_the_declassification_and_decriminalization_of_petty_offences.pdf.

7.3.5 Opportunities for parliamentarians

Parliamentarians as legislators, and in their oversight role of the executive branch of government, have the following responsibilities and opportunities for strengthening protections for key populations in laws and policies:

- Advocate through legislative committees and national assemblies for the urgent review of criminal laws regarding same-sex sexual activity, sex work and drug use in order to align them with relevant regional, continental and international human rights instruments, model laws, and standards and guidelines for their protection and their right to health.
- Propose new or amended laws, in committees or as private member's bills, for greater protection for the human rights and health of key populations.
- Through public statements, interventions in national assemblies, and work on committees, call attention to member states' obligations under relevant regional, continental and international human rights instruments, including model laws, to protect the human rights and health of all individuals, including key populations.
- Advocate through relevant committees and interventions in national assemblies for the provision of adequate technical and financial resources to national human rights institutions so that they can be responsive and accountable for protecting and promoting the human rights of all individuals, especially key populations.
- Through legislative committees and interventions in national assemblies, ensure that the judiciary, beginning from the magistrate levels, has sufficient financing and technical support to perform their roles to protect and promote the human rights and health of key populations, as well as all other individuals that come before them.
- Through relevant committees and interventions in national assemblies, ensure that national human rights institutions receive adequate financial and technical support to carry out their responsibilities for promoting law and policy reform for the protection of key populations.
- Participate in relevant oversight mechanisms, such as National AIDS Councils and other multi-sectoral oversight bodies, as well as through parliamentary committees, to monitor and hold accountable relevant officials for the full implementation of policies aimed towards protecting and promoting the SRH of key populations.

7.4 Ensuring access to information and services

7.4.1 Rationale

HIV and SRH services for key populations are becoming more and more available across member states. This includes comprehensive SRH programmes developed based on best-practice guidance and, in some states, provision of harm reduction interventions, including opioid substitution therapy, as well as improvements in services for detainees.

As important as all of these efforts are, they are almost exclusively financed by donors and are operating outside the public health sector in many instances and not accessible to all who need them. Within the public health sector, the health needs of key populations continue to be almost invisible with most information about SRH, including about HIV, not reflecting issues of diversity, sex work or drug use. In most member states, information for people in prisons does not address sexual behaviour or drug use except in harsh and punitive terms.

Older adolescents, 15 to 17 years, including those from key populations, are mostly unable to access comprehensive, age-appropriate information and services regarding sex, sexuality, reproductive health and diversity. This increases their vulnerability to HIV, STI and other SRH complications. It also increases their vulnerability to sexual and physical exploitation and abuse.

The following minimum standards will guide Parliamentarians and member states to ensure that relevant, acceptable and sustainable information and services are available to all members of key populations, as well as healthcare workers, school authorities, law enforcement agents, other relevant stakeholders, and families in communities, regardless of their geographic, economic or social situation.

7.4.2 General standards

Minimum packages of services are defined for key populations, relevant to country needs and contexts, to ensure clarity regarding what services individuals can expect to receive and what services healthcare professionals are expected to provide.

Minimum packages are defined with due regard to regional, continental and global technical guidance for comprehensive service provision. The packages are also designed with the full participation of those key population groups whose health needs they are meant to address.

Policies and plans are in place to ensure that healthcare services for key populations are integrated within essential services packages delivered through the public health sector for all health service users.

Healthcare information, particularly information about SRH, is inclusive, non-discriminatory and reflects the diverse needs of all health system users.

Minimum standards for HIV, TB, STI and hepatitis services in prisons are fully domesticated, implemented and monitored.

National recurrent budgets for the health sector include adequate provisions are funding services for key populations. Sustainability and transition plans are in place for when donor support ends.

Adolescent and youth-friendly programmes within the health sector are inclusive and have the technical and operational capacity to respond to the needs of adolescents and young people from key populations, including those living with HIV.

The rights of adolescents and young people to comprehensive, inclusive and age-appropriate information about their SRH are promoted and upheld.

7.4.3 Opportunities for parliamentarians

Parliamentarians, through their oversight role of the executive branch of government, have the following responsibilities and opportunities for strengthening programmes and services for key populations:

- Routinely request, through portfolio committees, that information be made available on the provision of services to key populations, including their content, coverage and how they are financed.
- Make requests of health ministers and other relevant officials to put in place SRH service packages and service standards for key populations, and to report on progress and coverage on a routine basis.
- Routinely engage with key population networks on the availability, accessibility, acceptability, quality and affordability of HIV, SRH and other health services, and report on findings through participation in parliamentary committees, interventions in national assemblies, as well as through public statements.
- Request during budgeting processes that adequate provision be made to finance and sustain programmes and services for key populations; and, through budget oversight mechanisms, ensure that these funds are available and absorbed.
- Advocate for the domestication, implementation, financing and monitoring of model laws and other minimum standards and guidelines that also address the health and information needs of key populations.
- Request, through participation on portfolio committees, and through interventions in national assemblies, that policies be put in place guaranteeing the right to comprehensive, age-appropriate information on sexuality and diversity for all adolescents and young people. Further request that regular reports on progress be made.
- Request, through participation on portfolio committees and through interventions in national assemblies, that legal or regulatory mechanisms be put in place to ensure that health information provided through the public sector is fully reflective of the diversity of health information needs.

8. IMPLEMENTATION AND MONITORING OF THE MINIMUM STANDARDS

This section outlines the steps to be followed by parliamentarians, the SADC Parliamentary Forum, Key Population Networks and the SADC Secretariat to ensure that these minimum standards are domesticated, implemented, adequately resourced and routinely monitored.

8.1 Roles and responsibilities for implementation

8.1.1 Parliamentarians

Parliamentarians have the following roles and responsibilities in relation to the minimum standards:

- As members of national assemblies, parliamentarians should take up all opportunities, in portfolio committees and through interventions in national assemblies, to call for ratification of the minimum standards, and to lobby for their domestication in national laws, policies and programmes.
- As legislators, parliamentarians should take up all opportunities, in portfolio committees and through interventions in national assemblies, such as private members bills, to advocate for and to bring about necessary changes in laws, regulations and policies as set out in these minimum standards, once they have been domesticated.
- As publicly accountable figures and role models, parliamentarians should 'lead by example' in embracing diversity; in championing justice, equity and dignity; and in condemning all acts of stigma, discrimination and violence, in all their forms, against key populations.
- As overseers of the executive, parliamentarians should ensure that policies and programmes are developed, implemented and monitored in full alignment with these minimum standards.
- As stewards of the public purse, parliamentarians should ensure that sufficient appropriations are made from domestic sources to support programmes to protect key populations and that the use of these funds is strictly monitored.
- As representatives and participants in regional and continental fora and mechanisms, parliamentarians should raise awareness about the minimum standards, and should take full advantage of opportunities to learn from peers in other jurisdictions who have similarly moved to increase protections for key populations and to guarantee their access to relevant health programmes and services.

8.1.2 SADC Parliamentary Forum

The Parliamentary Forum, with support from the Secretariat, will coordinate the overall implementation and monitoring of these minimum standards and ensure harmonization across the region. The specific responsibilities will include:

- Dissemination and popularization of the minimum standards to stakeholders at regional and international levels;
- Advocating for the ratification, domestication and implementation of the minimum standards across the region in line with existing commitments made by member states;
- Facilitating training, skills transfer and the documentation and dissemination of best practices in relation to protecting and promoting of the health of key populations in all member states; and
- Coordinating partners around resource mobilization and technical support in the region for the ratification, domestication, implementation and monitoring of the minimum standards.

8.1.3 Key population networks

Key population networks include regional, national and local level networks and civil society organisations led by key populations as well as entities working with or allied to these groups. The role of these networks and allies will be to:

- Promote the existence of the minimum standards through their respective channels and to advocate for their ratification, domestication and implementation at member state levels;
- Collaborate with other stakeholders to establish multi-sectoral process for monitoring and accountability for applying the minimum standards across the health sector;
- Collaborate with Parliamentarians to define opportunities for initiating urgent law and policy change;
- Collaborate with Parliamentarians and other stakeholders to advocate for sufficient financing, including from domestic sources, for full implementation and monitoring of the minimum standards; and
- Continue to participate in the SADC Parliamentary Forum and other relevant organs to ensure effective monitoring and accountability for progress and for sharing technical expertise and best-practice models.

8.1.4 Other stakeholders

Other stakeholders include United Nations agencies, bilateral donors and development partners, local and international non-governmental organizations, the private sector, and research and training institutions. Their role will be as follows:

- Provide technical support to parliamentarians and the SADC Parliamentary Forum for the ratification, domestication, implementation and monitoring of the minimum standards.
- Popularize, advocate for and promote the recognition and prioritisation of these minimum standards at national, regional and international levels.
- Support resource mobilization for the implementation of the minimum standards at regional and national levels; and
- Conduct operations research, and document and disseminate lessons learnt and emerging best practices.

8.2 Monitoring and accountability mechanisms

The efforts of parliamentarians to drive the implementation of these minimum standards in member states, and to be accountable for making progress, will be monitored and supported through national and SADC level processes and mechanisms.

8.2.1 Member state level

Within their national jurisdictions, Parliamentarians have the following opportunities for putting in place and participating in the following monitoring, reporting and accountability mechanisms:

- Parliamentarians, on their own and through portfolio committees, can request that relevant Ministries and national institutions collaborate with key population networks to identify indicators, targets and mechanisms for monitoring the implementation of the minimum standards and for routinely reporting on progress.
- Parliamentarians, through portfolio committees in health or justice, can commit to issuing annual reports on progress for the protection of key populations aligned with the minimum standards.
- Parliamentarians can collaborate with key population networks and other stakeholders to ensure that compliance with the minimum standards informs member state reporting on health and human rights through treaty-based bodies, such as the African Peer Review Mechanism, the African Charter of Human and People's Rights, the Universal Periodic Review, and the Convention on the Elimination of Discrimination Against Women (CEDAW).

8.2.2 SADC regional level

At the regional level, parliamentarians and their member states have the following opportunities for monitoring the ratification, domestication, implementation, and financing for the minimum standards:

- Through participation on the Regional Model Laws Oversight Committee, parliamentarians have opportunities to report on progress from their respective member states, to share best practices and lessons learnt, and to table ongoing challenges. The Committee itself can then make reports to plenary assemblies on regional progress, lessons learnt, ongoing challenges and areas for improvement or amendment regarding the minimum standards.
- Through participation on other standing committees of the Forum, such as the Standing Committee on Human and Social Development and Special Programmes, parliamentarians have additional opportunities to routinely report on progress in their member states regarding the implementation of the minimum standards.
- Through their participation in plenary assemblies of the Forum, parliamentarians can report on their own progress and hold others to account for using the minimum standards to improve protection for key populations.

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