The Missing Piece of the Puzzle

RIGHTS+EQUITY+JUSTICE for HIV PREVENTION

Civil Society Call to Action:
Address structural barriers to HIV!

In June 2016, at the United Nations High-Level Meeting (HLM) on Ending AIDS, countries pledged to leave no one behind and end the AIDS epidemic as a public health threat by 2030 and reach ambitious milestones by 2020.

The 2020 targets:

- reduce AIDS-related deaths
- reduce new infections

} to less than 500 000

While new HIV infections are decreasing in Southern Africa, this is not happening at a rate which puts the 2020 goals within reach.

We need to address structural barriers to HIV prevention in order to stop the epidemic!

2019

ARASA AIDS & Rights Alliance for Southern Africa

Background

The High Level Meeting in 2016 set specific programme targets for HIV prevention, supported by 5 pillars.

Pillar		2020 Target
adolescent girls and young women (AGYW)	1	90% coverage for combination prevention and their male partners
key populations (KP)	2	90% coverage for combination prevention
condom programming	3	90% of key populations have access to condoms
male circumcision	4	90% men aged 15-29 circumcised in 10 priority countries
prophylaxis (PrEP)	5	10% of populations at higher risk have access to PrEP

Many of the barriers which hamper progress in HIV prevention are structural.

Structural issues are the ***'upstream'*** factors: environmental conditions outside the control of individuals which influence their perceptions, behaviour and health.

Structural barriers include:

- patriarchy
- heteronormativity
- gender inequality
- violence, and
- legal and policy barriers.

For example:

- **In 10 countries in East and Southern Africa, laws and policies that require parental consent to access SRH services discourage adolescent girls from accessing services they need to stay healthy.[1]**
- **Intimate partner violence experienced by ever-married women or partnered women is declining steadily in the region, but remains unacceptably high, ranging from 15 – 30% in surveys.[2]**
- **Discrimination in health-care settings still occurs, especially towards key populations.**
- **Most countries in the SADC region criminalise same-sex sexuality (with the exception of Angola, Mozambique and South Africa), sex work and drug use.**

Structural interventions include:

Structural interventions are the missing piece of the puzzle that will catalyse HIV prevention in the region.[3]

- strengthening legislation to end intimate partner violence (IPV)
- increasing girls' access to secondary education
- empowering women economically
- removing barriers to sexual and reproductive health rights (SRHR) such as requiring permission from parents or guardians to access medical treatment[4]
- decriminalising same-sex relationships, sex work and drug use and possession for personal consumption; and
- bringing to scale community empowerment programmes that have been proven to reduce stigma, discrimination and marginalisation.

Successfully addressing the structural barriers[5] to HIV prevention cannot happen without the actions, perspectives and networks of civil society, including community-based and key population organisations. Because they understand local contexts, civil society organisations are best placed to reflect and amplify the HIV prevention needs and challenges of communities, particularly adolescent girls and young women, and key populations. In addition to providing much needed prevention services, they are able to identify gaps, and other challenges, in the HIV prevention response at various levels, and to advocate for evidence-informed, rights-based interventions to be implemented at a scale sufficient to make an impact on reducing new HIV infections and meeting a target of the 2016 Sustainable Development Goals, to end AIDS as a public health threat.

Although civil society organisations working on HIV prevention play such a critical role, the sector experiences many challenges, including capacity constraints, funding and sustainability challenges, and a lack of meaningful inclusion in what should be multi-sectoral spaces. Nevertheless, many opportunities now exist in the regional and global advocacy space.

Why a "Call to Action"?

In April 2019, the AIDS and Rights Alliance for Southern Africa (ARASA), with support from the Partnership to Transform, Inspire and Connect the HIV Response (PITCH) convened 35 civil society activists from 10 SADC countries for the 2nd Activist meeting on advocacy for the elimination of structural barriers to HIV prevention.

Together, the civil society activists:

➔explored progress on the implementation of a range of regional commitments which SADC countries have made on HIV prevention.

➔reviewed the involvement of civil society in national and regional HIV prevention platforms and processes.

➔explored good practise in advocacy by civil society organisations in Southern Africa for the elimination of structural barriers to HIV prevention.

➔explored opportunities to advocate for an acceleration of efforts to address structural barriers to HIV prevention; and to amplify much needed collective visibility at regional level to address the urgency of this issue

The full report of the 2nd Activist Meeting can be found here on the ARASA website.

This "Call to Action" summarises key consensus, recommendations and action points from the meeting, as a call to action for civil society in southern Africa to step up advocacy and action for the removal of structural barriers to HIV prevention. It should be used as an accompaniment to the 5 Issue Briefs developed by ARASA as a resource to support civil society advocacy for the removal of structural barriers to HIV prevention.

Regional priorities to address structural barriers to HIV prevention

The participants of the 2nd Activist meeting on advocacy for the elimination of structural barriers to HIV prevention agreed that social, cultural and religious norms, and particular patriarchy and heteronormativity are overarching structural barriers to progress in ending HIV as a public health threat. These harmful norms impact all of the 5 pillars, as they drive punitive, stigmatising and discriminatory attitudes towards key populations, women and young people. Further, these attitudes are used to justify violence against women and marginalised people.

Key actions to address structural barriers per HIV prevention pillar:

All of the actions identified below are framed by an approach which works to eliminate patriarchy and advance gender equality. Furthermore, actions should be intersectional in that they acknowledge and address differences in power, privilege and access based not only on gender, but also on class, ethnicity, ability, sexuality and other dimensions. All actions should be inclusive of young key populations.

I. Adolescent Girls and Young Women

1. Advance comprehensive sexuality education using a sexual and reproductive health and rights framework;
2. All stakeholders to strengthen dissemination, awareness, education and uptake of key policies, including the *Maputo Protocol*,[7] the *SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage*;[8] and Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region;[9]
3. Work with boys to shift gender norms and prevent gender-based violence; and
4. Age of consent laws with regards to consent to medical procedures, including termination of pregnancy, consent for sex, and consent for marriage should be harmonized throughout the region. There should be no age of consent barriers to accessing PrEP.

II. KEY POPULATIONS

1. Address the serious data gaps in KP strategic information, including population size estimations and integrated bio-behavioural surveys (IBBS), with particular attention to the dire data gaps on transgender people and PWID;
2. Ensure that key population members are involved in the data gathering and analysis processes;
3. Prioritise legal and policy reform, including the decriminalisation of sex work, same-sex sexuality and drug use and possession for personal use;
4. Acknowledge the mental health burden faced by key populations, which, to a great extent, is influenced and exacerbated by stigma, discrimination, violence and criminalisation, and the contribution of this mental health burden to poor HIV outcomes, and therefore improve access to psychosocial support and services for key populations;
5. Acknowledge that key populations lack adequate service coverage, and that governments should demonstrate political will by scaling up such services; and
6. Ensure that adequate funding is allocated to key population-led organisations and those which meaningfully involve key populations.

III. CONDOM USE

1. Address harmful gender norms which deter women from obtaining, carrying and using condoms, including those which view carrying condoms as evidence of sex work;
2. Appreciate that those who use and need access to condoms are diverse. Therefore, condom packaging and messaging needs to appeal to people in their diversity;
3. Ensure that condoms are widely available in both urban and rural communities, in a wide variety of locations, including outside of health facilities, including places where people can help themselves out of sight of others (such as in public toilets);
4. Ensure that condoms are widely available to key populations, in prisons, and in places frequented by young people; and
5. Despite the collapse of social marketing programmes, governments have an obligation to ensure adequate supply of free condoms.

IV. VMMC

1. VMMC will work best and be most sustainable if it is integrated into primary health care, and in particular into sexual and reproductive health care. It should also be integrated into school health and into the comprehensive sexuality education (CSE) curriculum;

2. Develop locally appropriate interventions, including local information, education and communication (IEC) messaging based on local beliefs and practices. Community must be involved in crafting demand creation messages;

3. Health care providers should be equipped to provide individualised information in face-to-face discussions, rather than generic, one-size-fits-all messaging; and

4. VMMC should not be imposed on transgender girls, as the foreskin can be used later in gender reassignment surgery.

V. PrEP

1. We must be pushing for better evidence, that includes community-generated evidence, and evidence which includes meaningful consultation with communities;

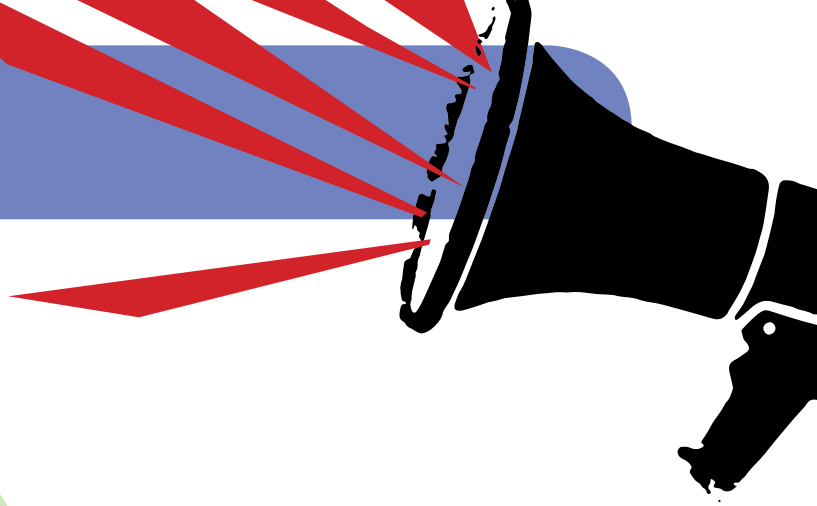
2. PrEP must be available for people who want it, and not just for specific populations;

3. We must create demand for PrEP as part of a comprehensive prevention approach, and supply must meet the demand;

4. PrEP must be provided in a person-centred way,that provides information and allows people to decide for themselves; and

5. Processes to develop national guidelines must include meaningful community engagement in order to strengthen local ownership.

Priority structural barriers for regional advocacy



In addition, the activists identified the following three structural barriers and related actions as priorities for a regional campaign to eliminate structural barriers to HIV prevention:

I. Legal and policy barriers
II. Information, knowledge, evidence, data
III. Funding and sustainability

I. Legal and policy barriers

Main Barriers

- Punitive and restrictive laws and policies are still widespread in the SADC region and are a major structural barrier to HIV prevention. Most countries in the region still criminalise same-sex behaviour, sex work, and drug use and possession. In most countries transgender people are also not afforded the right to change their gender markers.
- Age of consent laws, such as age of consent for accessing sexual and reproductive health information, services and treatment, for sex, and for marriage, are a barrier to the sexual and reproductive health and rights of young people, including impeding their ability to protect themselves from HIV.
- SADC governments have made a variety of global, continental and regional commitments to uphold health and rights for all. Encouraging progress has been made in the policy sphere at regional level, for example with the adoption of the 2017 SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations and the 2018 Regional Strategy for Sexual and Reproductive Health and Rights as well as the 2018 Standards for the Protection of the Sexual and Reproductive Health of Key Populations in the SADC Region. Uptake of these policies at national level is, however, too slow.

Key Actions

➔ Civil society must continue to actively advocate and lobby for the removal of legal and policy barriers, including through strategic litigation amongst others;

➔ Where policies and standards which enshrine sexual and reproductive health and rights exist, civil society must advocate for their implementation, and leverage available accountability mechanisms to ensure this;

➔ Civil society is a critical stakeholder in multi-sectoral national and regional processes, and should meaningfully participate in these processes. They should also advocate for these spaces to be inclusive, representative and accessible.

II. Information, knowledge, evidence, data

Main Barriers

- There are gaps in critical data, including size estimates, relating to key populations in the region (most critically regarding transgender people and PWID). These data gaps are often reflective of a lack of political will to protect the rights and health of these people, and perpetuate denial and inaction by governments.

- Evidence is the key to unlocking investment in programming to address structural barriers. Research into the impact of structural barriers to HIV prevention, and interventions to address these barriers are more complex than research on biological and behavioural factors. Fortunately, this body of research is growing. Civil society, community and key population organisations have access to rich, valuable information on interventions to address structural barriers because they are in direct contact with communities, but tend to face various constraints, including lacking technical capacity in accessing, using and generating evidence.

Key Actions

➔ Civil society should be proactive in leveraging and using the data and information which they have access to, in order to bolster their advocacy efforts. They need to be smart about documenting, publishing and disseminating their evidence.

➔ Moreover, they need to challenge HIV prevention discourse which is either not informed by evidence and human rights, and/or is grounded in morality-based arguments.

➔ Where there are data gaps, civil society should advocate for investment in research to fill those gaps. Alternatively, civil society can generate its own evidence, and then advocate for its uptake.

➔ Governments and development partners should not hold onto data and information but must make a concerted effort to disseminate same to civil society and community-based organisations.

III. Funding and sustainability

Main Barriers

- SADC countries have committed, as part of the 2016 HLM Political Declaration, to spending one quarter of their total HIV budget on prevention, and to ensuring that at least 30% of service delivery is community-led by 2020. These targets are unlikely to be met.

- There is inadequate domestic funding for HIV prevention in most countries in the region, with countries still being highly dependent on international funding.

- Key population programmes remain underfunded, with almost no investment of domestic resources in most countries in the region. As a result, HIV prevention interventions are not being implemented at sufficient scale to impact positively on HIV infection rates amongst these populations. This is also linked to the lack of data for some groups as investment decisions are made based on analysis of key data linked to size of population and HIV prevalence rates amongst these groups.

Key Actions

➔ Civil society must push for commitments relating to funding and sustainability, including the HLM Political Declaration HIV prevention commitments, to be honoured.

➔ The push for Universal Health Coverage (UHC) is becoming increasingly important globally, particularly in regard to health financing decisions. This includes an important discussion regarding financing of civil society organisations through social contracting. Therefore, it is important for civil society to be prepared, to educate ourselves, and to be ready to influence debates to ensure that HIV prevention and removal of structural barriers is prioritised. Civil society should also increase their understanding of social contracting by governments and consider the implications this may have in the long-term.

➔ Civil society should be meaningfully consulted and included in decisions regarding funding priorities and funding allocations. This requires for civil society to strengthen their understanding of health financing as well as national budget and expenditure tracking.

➔ Key population-led organisations are best placed to reach and engage with key population communities, and know what works and does not work. Their knowledge and expertise are critical to the effectiveness of programmes, and supporting and adequately funding key population organisations will extend the reach and effectiveness of key population programmes. These organisations should be included in social contracting by governments.

End Notes

[1]UNFPA (2017). Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights: a review of 23 countries in East and Southern Africa

[2]Fast-Tracking Prevention in Eastern and Southern Africa – on what do we focus and how? HIV Epidemic Overview 2018. Presentation by Alankar Malviya, Senior Adviser UNAIDS Regional Support Team
Eastern and Southern Africa at ARASA 2nd Activist meeting on advocacy for the elimination of structural barriers to HIV prevention

[3]See ARASA explainer video on structural interventions: https://www.youtube.com/watch?v=0gYG6JTao6w
[4]Age of consent to medical treatment

In many countries, the age of consent to receive medical treatment, including access to contraceptives and HIV counselling and testing, is not provided for in laws and policies. Lack of legal and policy provision can lead to confusion as to when young people can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.

[5]Structural drivers of HIV are forces in the social, political, economic, legal and cultural environment, which exert an influence on individuals and groups

[6]Angola, Botswana, eSwatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Zimbabwe and Zambia.
[7]The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol, guarantees comprehensive rights to women including the right to take part in the political process, to social and political equality with men, improved autonomy in their reproductive health decisions, and an end to female genital mutilation. Available at http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf

[8]SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, 39th Plenary Assembly of the SADC PF, Kingdom of eSwatini, 2016. Available: https://www.girlsnotbrides.org/wp-content/uploads/2016/10/MODEL-LAW-ON-ERADICATING-CHILD-MARRIAGE-AND-PROTECTING-CHILDREN-ALREADY-IN-MARRIAGE.pdf

[9]SADC Minimum Standards for the Integration of HIV and Sexual and Reproductive Health. SADC, 2015. Available at https://resourcecentre.savethechildren.net/sites/default/files/documents/sadc_minimum_package_of_services.pdf

About ARASA

The AIDS and Rights Alliance for Southern Africa (ARASA) was established in 2002 as a regional partnership of civil society organisations working in 18 countries in southern and East Africa. Between 2019 and 2021, the partnership will work to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and wellbeing in southern and East Africa.

ARASA
53 Mont Blanc Street
Windhoek, Namibia
Tel: +264 61 300381
Fax: +264 61 227675
Email: communications@arasa.info

@_ARASAcomms
@AIDSandRightsAllianceforSouthernAfrica
@ARASA_network

ARASA AIDS & Rights Alliance for Southern Africa

The Partnership to Inspire, Transform and Connect the HIV response (PITCH) enables people most affected by HIV to gain full and equal access to HIV and sexual and reproductive health services.

The partnership works to uphold the sexual and reproductive health and rights of lesbian, gay, bisexual, and transgender people, sex workers, people who use drugs and adolescent girls and young women. It does this by strengthening the capacity of community-based organisations to engage in effective advocacy, generate robust evidence and develop meaningful policy solutions.

PITCH focuses on the HIV response in Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam and Zimbabwe. Partners in these countries also share evidence from communities to influence regional and global policies that affect vulnerable populations.

PITCH is a strategic partnership between Aidsfonds, FrontlineAIDS and the Dutch Ministry of Foreign Affairs.

PITCH Partnership to Inspire, Transform and Connect the HIV response

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FRONTLINE AIDS

Ministry of Foreign Affairs