

ANALYSIS

SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018)

In 2018, Positive Vibes developed "Sentinels | signs and signals in a changing environment: A synopsis of sexual and reproductive health, and sexual and reproductive rights (SRH-R) for sexual and gender minorities (LGBTQ+ persons) and sex workers in the African context". That analysis explored the human rights, policy, legal, programming, financial and advocacy environments around LGBTQ+ people and sex workers in fourteen countries in Southern, East, West and Central Africa, six of which are SADC Member States. In 2019, with the release of the SADC Regional Strategy – and in support of its "Bridging the Chasm" regional SRH-R project – Positive Vibes has conducted an analysis of that strategy as a supplement to "Sentinels", to identify any material changes in the SRH-R environment for sexual and gender minorities – in policy, practice, strategy or approach – that signal shifts in ways of thinking and ways of working.

This critical analysis is presented as a tool for reflection and discussion, reviewing the SADC Regional Strategy for significance, relevance and appropriateness within a broader context of rights-based approaches to health and development.

In a Foreword to the document, the SADC Executive Secretary describes the Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations as a "result of a series of participatory and interactive processes that involved members of key populations, governments, civil society and development partners."

With reference to the SADC Regional Strategy, the following observations are made:

1. Section 8 of the Strategy describes **Purpose, Outcomes and Key Results** – the logical framework around which the strategy is designed.
 - a. Its **PURPOSE**: to guide the adoption and instrumentalization of a standard, comprehensive package that addresses the unique challenges in providing equitable and effective HIV and SRH rights and services to Key Populations in SADC.
 - b. Its **GOAL**: to serve as a guide to SADC Member States¹ in designing and implementing appropriate SRH and HIV prevention, treatment and care programmes for key populations focussing on the major issues that need to be addressed at policy, legal, institutional and facility levels. Members States will use the strategy to:
 - i. Design and implement effective SRH and HIV prevention, treatment and care programmes for Key Populations;
 - ii. Design a package of services for key populations in line with the standard package of services as prescribed in the regional strategy;
 - iii. Ensure active and meaningful participation of key population groups in the design and implementation of the regional strategy at national and sub-national levels
 - iv. Mobilise governmental and non-governmental organisations, civil society organisations and other stakeholders around a set of proven strategies based on their comparative advantages.

¹ Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbabwe

- c. Its RESULTS/OUTCOMES: the strategy is expected to increase availability of SRH and HIV services to all key populations in the SADC region; design and implement holistic strategies covering policy, legal, institutional and facility levels; increase access to quality, comprehensive HIV and SRH services for key populations in all Member States such that 90% of key populations are accessing services; and ensure adequate and sustainable resource mobilisation and utilisation for HIV and SRH services for key populations.

Four Key Result Areas are indicated:

- i. Stigma and discrimination against key populations are eliminated, particularly at service provision points
- ii. Violence against key populations is significantly reduced
- iii. SRH and HIV prevention, treatment, care and support are scaled up for key populations, and especially young key populations (core package of services; evidence informed; results oriented)
- iv. Reduction in legal, policy and cultural barriers which impede access to services for key populations.

2. In relation to the **framing of the strategy** itself:

- a. The document does not indicate any time period for which the strategy applies, or when it is expected to conclude.
- b. The strategy – released in 2018 – is the result of consultation processes with SADC Member States through representation of National AIDS Councils (2012); meetings of the African Key Populations Experts Groups with UNDP, SADC, and regional civil society organisations (2014); Working sessions and a regional consultation on people left behind convened through UNAIDS (2014); and two regional consultations with convened by the SADC Secretariat and UNDP with young key populations and Member States (March 2017). The draft document was validated in October 2017 and “approved, in November 2017, by SADC Ministers responsible for Health and HIV and AIDS.”
- c. Despite at least six years of consultation and development, however, the document states (p.11):

“The strategic framework is not a strategic plan, but a guiding framework for SADC Member States. It aims to...provide details...key barriers...and steps Member States can take to address these obstacles...”

This raises several questions:

- Does “approval” by SADC Ministers of Health equate to political endorsement and intention by Member States?
- If a “Regional Strategy” developed through six years of consultation issues the disclaimer that it is “not a strategic plan, but a guiding framework” to identify steps States might take, what mechanisms exist through SADC for accountability of Member States to the process and outcomes? Does the Strategy have any legs to stand on? Does SADC have any teeth? And what is the role of civil society beyond the participation in consultations now that the “strategy” is developed and released?
- Do country-level civil society organisations working in health and rights of sexual and gender minorities have sufficient relationship and access to National Ministries of Health and technical response structures (eg. Technical Working Groups) to test whether any extraordinary commitment exists domestically as a result of the SADC Regional Strategy?

3. The document provides **two helpful incentives for action**, however:
 - i. That, whilst new HIV infections continue to decrease, the rate of decrease is slowing since 2010. And, in some cases, there is an increase in new infections. There is a need for SADC to “increase our investment in prevention.”
 - ii. Under the 2016 High Level Political Declaration, an ambitious target for HIV prevention has been set, expecting countries to reduce their new adult infections by 75% by 2010, compared to 2010 levels. SADC countries are under pressure to meet the 2020 prevention target.

4. Pages 6-8 of the Strategy outlines a Glossary of **Terms and definitions**. It is worth noting that:
 - a. *Gender-based violence* draws its definition from CEDAW, and misses an opportunity to broaden the definition of gender to go beyond “affects women disproportionately”.
 - b. A definition of *healthcare* concludes with an obscure statement that leaves questionable room for interpretation around universally acceptable minimum standards and human rights: that “*health has many dimensions and is largely culturally defined*”.
 - c. In a definition of *human rights*, the document – that sets out to be a guiding framework on strategy for “Key Populations” – lists explicit grounds for non-discrimination in the recognition of rights for all human beings: race, sex, nationality, ethnicity, language, religion. It avoids sexual orientation or gender. Similarly, in an explicit list of rights stated as examples, it does not include the rights to dignity, to equality under the law, to privacy.
 - d. In a definition of *key populations* – arguably a significant opportunity in a guiding document – the strategy misses, or avoids, several opportunities to advance a human-rights based perspective:
 - i. Key populations are presented as groups who are at increased risk of HIV because of higher-risk behaviours, who also often “have legal and social issues related to their behaviours”. There is something incredibly stigmatising about this single emphasis on behaviour in a regional strategy document, with no mention of biological factors that increase vulnerability, or the socio-legal barriers (that are functions of a poor human rights environment, not the behaviours of individuals and groups) that inhibit access to health, safety and justice.
 - ii. The definition suggests that Key Populations are “due to specific higher-risk behaviours, at increased risk of HIV irrespective of... local context”. This seems to be blatantly inaccurate, given that social, cultural, political and legal contexts greatly impact on risk and vulnerability for sexual and gender minorities. The statement virtually ignores structural injustice and the need for human rights reforms and legal protections.
 - iii. Despite the document’s frequent reference to “sexual and reproductive health rights” and “human rights”, there is no mention in the body text (apart from cited references) to the valid sexual identities of people: to “LGBT+” people; to lesbian women and other women who have sex with women; to gay men and other men who have sex with men.
 - iv. Key Populations are typically defined to include “men who have sex with men; people in prisons; people who use drugs; sex workers; transgender people”. Queer women, whose sexual and reproductive health needs and vulnerabilities are complex and specific, are entirely invisible; and with that erasure, a division created within the LGBTI movement that further exacerbates exclusion and marginalisation.

- v. "Men who have sex with men" are described to include "all men who engage in sexual and/or romantic relations with other men", an unusual consideration given the strong behavioural focus of preceding sections of the text. What is the HIV risk-compounding behavioural driver linked to non-sexual romantic relations between men?
 - vi. The document draws a distinction between "vulnerable populations" such as adolescent girls, orphans, street children, people with disabilities and migrant workers, and "key populations" (who are less vulnerable than they are prone to greater risk, owing to their behaviours).
- e. A definition of *Sexual and Reproductive Health* suggests that the "sexual and reproductive health rights" of all people must be respected, protected and fulfilled. This is an important distinction in a policy document of this level from "the sexual and reproductive rights" of all people: that is, the human rights to dignity, to equality, to privacy that includes the right to identity and the right to intimate choice; not simply the rights to health, that includes sexual and reproductive health services.

Further, the document presents no framework to define, illustrate or distinguish between Sexual Health, Reproductive Health, Sexual Rights and Reproductive Health. Nor does it propose an acceptable minimum standard against which these should be considered for key populations in Southern Africa. In as much as the strategy claims (p.11) to "operationalise current...commitments and address gaps by providing Member States with a framework to develop specific programming aimed at key populations" it demonstrates very little specificity. Member States are simply guided to use the strategy in conjunction with existing SADC initiatives (such as the SADC Strategic Framework on the integration of HIV, Tuberculosis, sexual and reproductive health and malaria that, in tone, is not specific to key populations nor focussed on human rights and legal reforms).

The definitions, in the way they are introduced at the beginning of the document, are important. They depict a way of thinking about sexual and gender minorities, about human rights, about the drivers of HIV, about sexual and reproductive health and rights, about structural reform. It is important that they have not only integrity (and adequately, accurately and satisfactorily reflect the identities of the persons the strategic framework purports to represent), but also consistency. With regards the latter, the document's positioning in terms of values and principles is inconsistent, reflecting a way of thinking that does not correspond to the spirit and language of the definitions.

- On p. 14, for instance, the document outlines Guiding Principles that underpin the regional strategy and are expected to guide its implementation. These include the rights of all persons to non-discrimination; to equality; to dignity; to security of the person. Stated principles also respect diversity of sexual orientation and identity, and choice of profession; and that the regional strategy is committed to uphold every person's right to equality, equity, dignity and freedom from stigma and violence.
5. In its introduction (p.8), the Strategy cites **statistical data** on the decline of new HIV infections and AIDS-related mortality among all ages in Eastern and South Africa between 2010 and 2016. Similar statistics are cited for HIV prevalence amongst Key Populations in Southern Africa (p.10). The document references, as well, global, continental and regional commitments and strategies, including the UNAIDS "Getting to Zero" strategy and the 2013 African Union commitment to eliminating HIV with the recognition of the need to strengthen rights-based protections for key populations. Of note:
- a. Relevant to a strategy specific to Key Populations, the document does not cite disaggregated data for declining new infections or AIDS-related mortality amongst key populations.

- b. Observation is made (p.10) that information on HIV prevalence among transgender persons is virtually non-existent in SADC. Could this be because several countries may not recognise trans people as “key populations” at policy level? Could this be because national health information systems make no provision for trans-people to be recognised in standard record-keeping by health facilities? Could this be because health facilities require trans people to present under a cisgender identity before providing them services (either informal socio-cultural pressure, or formal identification requirements to register for services)? Is this an opportunity for influence and advocacy?
 - c. In as much as data is quantified for incidence, prevalence and mortality, there is no reference to similar tracking around achieving the goals of “0 discrimination”, or how the 2013 AU commitments to rights-based protections are being systematically monitored.
6. Opportunities exist, in theory, for specific **Bridging the Chasm-integration** with the Regional Strategy, at both national levels and multi-country/regional levels:
- a. To analyse factors around poor data on trans health, propose options for response, and lobby for reform, together with trans communities and trans-led organisations. P.17 of the Strategy highlights the debatable “dearth of information on the needs of key populations in SADC making it difficult to provide effective programming”.
 - b. To model participatory monitoring at community and health facility levels. P.14 of the Strategy states that “key population groups are encouraged to be substantively involved in collecting reliable ground-level data, as well as analysing and corroborating the collected data.”
 - c. Budget monitoring on domestic and regional health expenditure, in general (perhaps, for instance, against commitments to the Abuja Declaration) and specifically, around financing for programming to sexual and gender minorities. P.17 of the Strategy suggests that “most countries do not dedicate funds for key populations. No country in SADC allocates specific funds for addressing the HIV needs of transgender populations as part of their HIV expenditure”.

The rationale for the SADC regional strategy is to focus on addressing these critical barriers to access encountered by sexual and gender minorities, in so doing assisting countries to meet their commitments and obligations to international and regional conventions.

7. The Regional Strategy proposes – across its four Key Result Areas – nine strategies (p.23) with, most importantly, **thirteen result indicators**. These indicators suggest opportunities for national technical participation to contribute to national progress, and opportunities for national and regional policy-level monitoring and accountability. Indicators include:

1	Number of Member States with institutionalised mechanisms to address stigma against key populations (including documentation of situations that put key populations at risk)
2	Number of Member States who have produced or updated a national key population stigma index.
3	Number of Member States providing legal aid services to key populations (to strengthen access to justice, in order to reduce violence against key populations)
4	Number of Member States implementing minimum basic packages of services for key populations (with access to technical support to develop a standard package of SRH and HIV services to all key populations)

5	Number of Key Populations or % of estimated key populations accessing combination prevention services in line with national guidelines and package of services
6	Number of Member States with functional technical working groups representing key populations in national AIDS response coordination mechanisms
7	Number of Member States having specific budget allocations for key population interventions and programmes
8	Number of Member States mobilising additional financial resources from development partners for key population interventions
9	Number of Member States conducting Integrated HIV Bio-Behavioural (IBBS) Surveillance studies of key population groups as per UNAIDS surveillance guidelines
10	Key population issues are included in the SADC regional research agenda
11	Number of Member States with mechanisms in place to ensure meaningful participation of key populations in the design and implementation of programmes (including participation in the collection of data for the development of policy and programmes)
12	Number of Member States with nationally validated legal environment assessments on HIV and SRH
13	Number of best practices on removing legal and policy barriers for key populations documented and shared.

It may be worth noting that:

- From a SADC perspective, indicators are at regional level, and relate largely to the existence of policies, structures and mechanisms at member state level. They do not speak to tracking results, impact or effectiveness of these strategies for sexual and gender minorities at a national or local level; to the implementation of policy to reduce barriers and increase access to services; to improved quality of life.
- The indicators place no requirement or expectation on any Member State – for whom the Regional Strategy exists – to effect legislative reform.
- As has already been mentioned, no timeframe is stated for the delivery of these results.
- No baseline data for these indicators across the fifteen Member States is provided in the Strategy document.
- Apart from standard, statutory procedures and processes, little provision is made for accountable monitoring. National AIDS Councils and Ministries of Health contribute annual national reports for compilation by the SADC Secretariat into an annual regional report to be presented at the joint Ministerial Meeting for Ministers of Health. Civil society, communities and representatives of sexual and gender minorities and other so-called key populations are not identified as contributors to that process of accountability (likely presumed to be incorporated through national structures).

The Strategy, arguably, does not introduce any novelty to the SADC region. It is unclear the extent to which it will challenge Member States to deviate from present practice, or the extent to which “approval” of the Strategy by Member States equates to practical, operational, accountable commitment to domestication and implementation. In

its conservativeness and timidity, one might question the relevance and effectiveness of the SADC Secretariat to effect any meaningful structural and practical change for marginalised and excluded sexual and gender minorities.

Whilst sexual and gender minorities are certainly excluded from comprehensive sexual and reproductive health services – and to an even greater extent, queer women and trans men remain unacknowledged and underserved – these populations are even more excluded from sexual rights and reproductive rights: to a large extent, a legal issue (as opposed to health policy and service access). The Regional Strategy presents very little challenge to Member States to take seriously the creation of more enabling human rights environments through legal reform that legitimise LGBTQ+ identities and sex work. Nor does it present challenge to governments to be accountable to their commitments and obligations through many regional and international human rights instruments. An argument might be made that addressing exclusion is not simply a matter of inclusive representation – a seat at someone else’s table; it is instead a matter of justice – equality under the law to exercise equal ownership of the place of meeting. Strategies for SRH-R cannot shy away from more assertive engagement with sexual and reproductive rights, and with legal reform, and with constitutional accountability.

There are, however, opportunities offered through the Regional Strategy, despite of – and perhaps even because of – its weaknesses and deficit in intention, for civil society organisations to identify entry-points through which to exercise accountability and amplify voice.