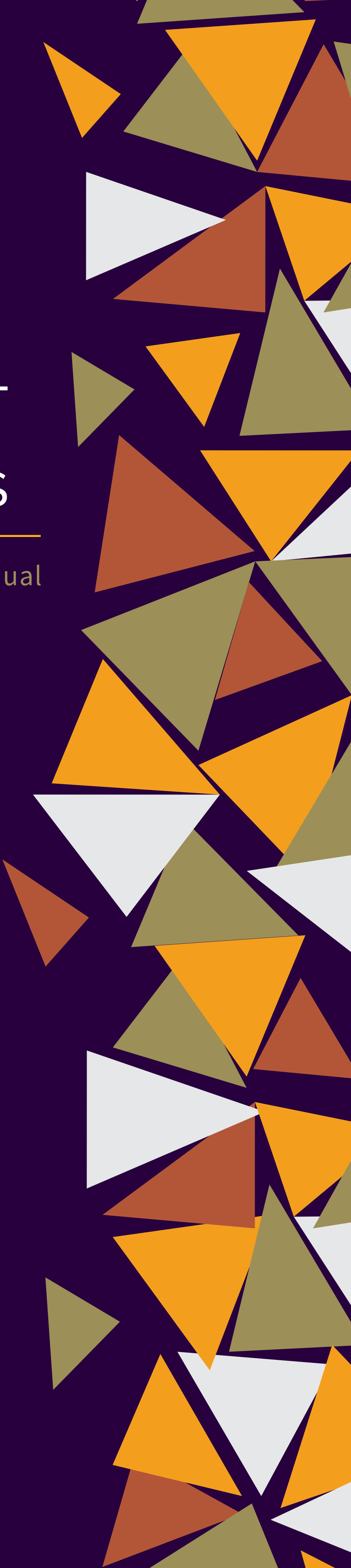
RESOURCE MANUAL FOR SADC PARLIAMENTARIANS

SRHR, HIV AND AIDS Governance Manual



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SRHR, HIV AND AIDS Governance Manual

SADC
Parliamentary Forum
Forum Parlementaire
Fórum Parlamentar

ARASA
AIDS & Rights
Alliance
for Southern Africa

Guide to icons used in this manual

Throughout this manual you will find icons relating to key Sexual and Reproductive Health and Rights (SRHR) issues. Follow these icons if you are interested in that topic in particular.

Human rights

Criminalisation

Women

Women living with HIV

Young women and girls

Child marriage

BE HEALTHY Viral load testing

Contraception

Abortion

Cervical cancer

Key populations

Treatment

Prevention

Stigma and discrimination

This icon indicates where you can find more information on a particular issue

This icon indicates a link to an online file for further reading

foreword

Over the past decade, Southern Africa, notoriously known as the epicentre of the global AIDS epidemic, has made significant progress towards increasing the number of people living with HIV who know their HIV status and have access to antiretroviral treatment, and towards reducing AIDS-related deaths.

This progress has however not benefitted everyone equally. Indeed, women and girls in Southern Africa remain at heightened risk of HIV infection and HIV lingers on as one of the leading causes of death for young women. Gender-based violence, discrimination and other human rights violations negatively affect their ability to protect themselves from HIV transmission, access Sexual and Reproductive Health (SRH) care, including HIV-related services, and prevent them from living dignified and healthy lives. Key populations, such as sex workers, gay men and other men who have sex with men, transgender people and people who use drugs, also face violence, stigma and discrimination which impacts negatively on their Sexual and Reproductive Health and Rights (SRHR).

HIV and the enjoyment of SRHR are inextricably linked in Southern Africa where HIV is largely transmitted through sex, often in a context where various forms of consensual adult sex, such as same-sex sexual conduct and sex work, are criminalised and deeply stigmatised. Moreover, individuals struggle to access information, care and support that is tailored to their needs in relation to both SRH and HIV services. Integrating SRH and HIV-related services can accordingly help to close critical gaps that limit access to quality of care for women, girls and key populations. An SRHR approach will also help eradicate stigma and discrimination which remain a significant barrier to HIV prevention, treatment, care and support.

At the governance level, parliamentarians have a key role to play in responding to the HIV, SRH and human rights challenges facing countries in the Southern African Development Community (SADC) region. Since 2014, the Southern African Development Community Parliamentary Forum (SADC-PF) has embraced its mandate to strengthen the capacity of SADC national parliaments to advocate for, and influence governance in the context of HIV and SRHR in the SADC region through its SRHR, HIV and AIDS Governance Project. The project is being implemented in Lesotho, Namibia, Seychelles, Zambia, Zimbabwe, Mauritius, and Tanzania with the aim of realising the long-term vision of equitable universal access to SRHR and HIV-related services, with a focus on improved health and rights for women and girls in SADC.

The role of parliamentarians in addressing HIV and SRHR-related challenges is paramount for the SADC region. The institution of parliament is a fundamental pillar representing the sovereignty of member states in accordance with their democratic and constitutional framework. Parliamentarians are thus perceived as enablers within the democratic system and they embody the will of the people in their representative capacity. Moreover, they are vested with oversight functions in parliament through parliamentary questions and motions, thus holding government to account on key issues, including SRHR. Parliamentarians are also endowed with the legislative function and as lawmakers, they can remove legal barriers and proceed with legislation which improve the SRHR and HIV landscape and protect women, girls and key populations from HIV infection. While parliamentarians are vested with the budgetary function of voting on the annual government budget for public expenditure, they have a central role in determining the amount to be voted upon on gender initiatives and HIV programmes, and questioning whether the funds are being appropriately allocated. Finally, parliamentarians are leaders and they can influence public opinion, particularly to dispel the misconceptions, stigmas and taboos surrounding HIV and SRHR.

SADC PF has a long-standing partnership with the AIDS and Rights Alliance for Southern Africa (ARASA), focused on supporting legislators in the SADC region to fulfil their role in addressing key and emerging HIV, SRH and human rights challenges.

We are pleased to have collaborated once again to develop this manual, which acknowledges the momentous importance of the institution of parliament and is expected to fortify knowledge on SRHR, improve skills and competencies and strengthen parliamentary functions.

Our hope is that this resource will assist members of parliament to be better able to deliberate on issues related inter alia to sexual and reproductive health and rights of women living with HIV, key populations, adolescent girls and young women; child marriage; contraception and family planning; abortion; cervical cancer prevention and screening; stigma and discrimination in health settings; antiretroviral treatment; HIV prevention and criminalisation of HIV transmission, exposure and/or non-disclosure.

We especially hope that the manual will serve as a guide to how members of parliament can help make a critical contribution to meeting the 90-90-90 targets of the Fast-Track approach to end HIV by 2030 and advance the human rights of people living with HIV, women and girls and key populations.

There is still much to do to reach the ambitious 90-90-90 targets and we will need the leadership and support of members of parliament every step of the way. We therefore trust that this manual will remain as a central tool for members of parliament to advance the SRHR, HIV and AIDS agenda in the SADC region.

Dr. Esau Chiviya

Secretary General
SADC Parliamentary Forum
February, 2018

Abbreviations and acronyms

AIDS	Acquired Immunodeficiency Disease
ANC	African National Congress
ARASA	AIDS and Rights Alliance for Southern Africa
ART	Antiretroviral Therapy
AU	African Union
CEDAW	Convention for the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CSW	Commission on the Status of Women
CRPD	Convention on the Rights of Persons with Disabilities
DRC	Democratic Republic of Congo
FGM	Female Genital Mutilation
GA	General Assembly
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IAPAC	International Association of Providers of AIDS Care
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IUD	Intrauterine Device
ITPC	International Treatment Preparedness Coalition
LGBTI	Lesbians, Gays, Bi-Sexual, Transgender and Intersex
LEEP	Leep Electrosurgical Excision Process
MDGs	Millennium Development Goals
NSPs	National Strategic Plans
OST	Opioid Substituion Therapy
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
RVLT	Routine Viral Load Testing
SADC	Southern African Development Community
SADC-PF	Southern African Development Community Parliamentary Forum
SDGs	Sustainable Development Goals
SOGI	Sexual Orientation and Gender Identity
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property
WHO	World Health Organisation
WTO	World Trade Organisation
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDH	Universal Declaration on Human Rights
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
VNRs	Voluntary National Reviews

Useful definitions

These definitions also appear at the beginning of relevant fact sheets.

Adolescence: the World Health Organisation (WHO) defines adolescence as a period of life with specific health and developmental needs and rights. It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles.

Adolescent: the WHO defines an adolescent as someone between the age of ten and 19.

Adolescent and youth-friendly health services: these are health services that are both responsive and acceptable to the needs of adolescents and youth, and which are provided in a non-judgmental, confidential and private environment, in times and locations that are convenient for adolescents and youth.

Behavioural interventions: these focus on encouraging safe behaviour including risk reduction counselling, comprehensive sexuality education, peer education and social marketing campaigns.

Biomedical interventions: these are interventions that use clinical and medical methods e.g. condoms and lubricants, antiretroviral therapy as prevention, Pre-Exposure Prophylaxis (PrEP), voluntary medical male circumcision, needle and syringe programmes.

Cervical cancer: this is a form of cancer that begins in the cervix and is largely caused by the Human Papilloma (HP) virus. It is a slow-growing cancer and in some cases, can take up to 20 years to develop.

Child: the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child define a child as a person below the age of 18.

Combination prevention approach: UNAIDS recommends that countries adopt an approach that provides packages of services, including biomedical, structural and behavioural components, tailored to priority populations in their local contexts.

Comprehensive Sexuality Education (CSE): this refers to provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality.

Domestic violence: this refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and/or controlling behaviours.

Early marriage: this term is often used interchangeably with child marriage, but it can also refer to marriage in a country where a child legally attains majority upon marriage, even when they are below the age of 18 when the marriage takes places.

Family planning: this is the information, means and methods that allow individuals to decide if and when to have children. This includes a wide range of contraceptives – including pills, implants, Intrauterine Devices(IUDs), surgical procedures that limit fertility, and barrier methods such as condoms – as well as non-invasive methods such as the calendar method and abstinence. Family planning also includes information about how to become pregnant when it is desirable, as well as treatment of infertility.

Forced marriage: this is a marriage that takes place without the full and free consent of one or both of the parties or when one or both of the parties is unable to leave the marriage.

Gender-Based Violence (GBV): this incorporates all acts perpetuated against women, men, boys and girls on the basis of their sex which causes or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict. It covers domestic violence, sexual harassment in the workplace, human trafficking and sexual and emotional abuse, to name a few examples. It includes sexual violence.

Gender identity: this refers to a person's persistent and consistent sense of being male, female or androgynous (in between). An internalised representation of gender roles and an awareness from infancy which is reinforced during adolescence.

HIV-related stigma: this refers to the negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and key populations, such as people who inject drugs, sex workers, men who have sex with men and transgender people.

HIV-related discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. Discrimination in the context of HIV also includes the unfair treatment of key populations, such as sex workers, people who inject drugs, men who have sex with men and transgender people. HIV-related discrimination is usually based on stigmatising attitudes and beliefs about populations, behaviours, practices, sex, illness and death. Discrimination can be institutionalised through existing laws, policies and practices that negatively focus on people living with HIV and marginalised groups, including criminalised populations.

Homophobia: this describes an irrational fear of homosexual feelings, thoughts, behaviours or people and an undervaluing of homosexual identities, resulting in prejudice, discrimination and bias against homosexual individuals.

Human Papillomavirus (HPV): this causes invasive cancer, including cervical cancer and is transmitted through sexual contact. Penetration is not required for transmission of HPV.

HPV vaccine: the vaccine is a form of primary prevention for cervical cancer. The first HPV vaccine was approved in 2006.

Hysterectomy: a surgical procedure (operation) to remove all or parts of the uterus.

Key populations in the context of HIV: groups that experience a high epidemiological impact combined with reduced access to services and/or being criminalised or otherwise marginalised. Key populations in the HIV response include gay, bisexual and other men who have sex with men; people who inject drugs, and/or who are sex workers; as well as all transgender people who are socially marginalised, often criminalised and face a range of human rights abuses that increase their vulnerability to HIV.

Legal age of consent: this usually refers to the age when a person can legally consent to sex.

Marriage: this is the union of persons by means of statutory, religious or customary law or practice or by means of a verbal agreement.

Minimum marriage age: this is the legal age at which someone can lawfully consent to marriage. Minimum marriage ages can be found in both statutory and customary laws and there is an evolving international consensus that the minimum marriage age should be 18.

Modern contraceptive methods: these include the pill, injectables, IUDs, implants, female and male condoms.

Palliative care: the WHO defines palliative care as "[A]n approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

Pap smears: this is a form of cancer screening by examining cells under a microscope. Cells are scraped from the cervix and examined for cancer or pre-cancerous changes. RoutineViral Load Testing (RVLT): this is the most accurate way of measuring the number of copies of HIV in the body.

Sex work: sex workers include female, male and transgender adults and young people (aged 18 – 24) who receive money or goods in exchange for sexual services, either regularly or occasionally.

Sexual orientation: this is the attraction between two people on various levels (emotionally, physically, intellectually, spiritually and sexually).

Sexual and reproductive health services: these include availability and access to services that support healthy sexuality and reproduction such as services and support to help women plan their families, including pre-conception support and/or access to contraception, as well as attention to infertility and cervical cancer screening and treatment.

Sexual violence: this refers to any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.

Structural interventions: these interventions promote an enabling environment, including decriminalising sex work, drug use and homosexuality, addressing gender inequality and GBV, promoting the rights of people living with HIV and key populations and reducing stigma.

Traditional contraceptive methods: these are abstinence (abstaining from sex altogether or abstaining from vaginal sex), or withdrawal (removing the penis from the vagina prior to ejaculation). These methods do not reliably prevent pregnancy and they cannot prevent Sexually Transmitted Infections (STIs).

Treatment adherence: for anti-retroviral therapy to work, people on treatment need to follow strict adherence which means taking their medication every day at the same time, or as prescribed by their health care provider. Poor adherence can be caused when people on treatment do not take their pills at the same time every day, when they forget a dose or when they stop taking some or all of their medication. Poor adherence can also be caused by stigma and discrimination.

Unmet need for modern contraception: these are women who want to prevent pregnancy but who do not use contraception or use traditional contraceptive methods. They may not use contraception for many different reasons: they may not have access to information or the commodities; they may not be able to afford contraception; they may be pressurised by sexual partners or family members not to use contraception and they may be coerced into sex without contraception.

Vulnerable and marginalised women (who struggle to access contraception and family planning): these include women and girls living with HIV, women and girls with disabilities, adolescent girls, displaced women and girls, refugee women and girls, sex workers.

Young people: the WHO's definition of young people, people between the ages of ten and 24, overlaps with its definition of adolescents.

introduction

1. Why was this manual developed and how to use it

Sexual and Reproductive Health and Rights (SRHR) and HIV are inextricably linked in Southern Africa where HIV largely plays out as a heterosexual epidemic, and is also transmitted during pregnancy and breastfeeding, in a context where same sex sexual conduct and sex work are often criminalised and deeply stigmatised. Despite some progress in reducing new HIV infections and expanding access to antiretroviral treatment (ART), Southern Africa remains at the epicentre of the global HIV epidemic. It also faces unacceptably high levels of gender inequality and gender-based violence (GBV).

The SRHR, HIV and AIDS Governance Project of the Southern African Development Community Parliamentary Forum (SADC-PF) aims to strengthen the capacity of Southern African Development Community (SADC) national parliaments to advocate for, and influence governance in the context of SRHR and HIV in the SADC region. The primary aim of the project is to realise the long-term vision of equitable universal access to sexual and reproductive health (SRH) and related rights and HIV-related services, with a focus on improved health and rights for women and girls in SADC. The project supports the realisation of regional and global political commitments, including Sustainable Development Goal (SDG) 3 – ensuring healthy lives and promoting the well-being of all at all ages, SDG 4 – ensuring inclusive and quality education for all and promoting lifelong learning, and SDG 5 – achieving gender equality and empowering women and girls.

Through the SRHR, HIV and AIDS Governance Project, parliamentarians will be better equipped to deliberate on issues related to SRHR and HIV, including child marriage, adolescent pregnancy, cervical cancer, contraception and family planning, and HIV prevention and treatment.

This manual is the key outcome of this project, developed by SADC-PF in collaboration with the AIDS and Rights Alliance for Southern Africa (ARASA) to build the skills, knowledge and values needed by members of parliament in SADC to execute their mandate.

The Mahé Declaration on Sustained Engagement by SADC Parliaments to Implement Resolution 60/2 of the Commission on the Status of Women on "Women, the Girl Child and HIV and AIDS".[1]
In July 2017, parliamentarians from 14 SADC countries met during a Regional Women's Parliamentary Caucus, hosted in Mahé, Seychelles where they adopted the Mahé Declaration, a framework for sustained engagement by SADC parliaments to implement Resolution 60/2 of the United Nations (UN) Commission on the Status of Women (CSW) entitled "*Women, the Girl Child and HIV and AIDS*". The declaration focusses on the HIV-related vulnerabilities of women and girls, and participating parliamentarians committed to advocate for the implementation of CSW Resolution 60/2, which calls for greater attention to the causes and consequences of the high levels of new HIV infections amongst young women and adolescent girls. On 13 July 2017, the Mahé Declaration was adopted by the 41st Plenary Assembly Session of the SADC-PF.

Commitments in the Mahé Declaration

Commit to using the framework for sustained engagement by SADC parliaments to implement the CSW Resolution 60/2 entitled "Women, the Girl Child and HIV and AIDS" to advocate for the implementation of Resolution 60/2 in an effort to address the root causes of the disproportionate burden of HIV among women and girls in the SADC region, and further advocate for the mobilisation of the requisite resources to implement the Resolution at the national level;

Request SADC-PF and its partners to support parliaments to advocate for the implementation of Resolution 60/2 through various activities including the dissemination of information, training, sensitisation workshops and if considered necessary, the development of Model Laws relating to the various issues of HIV and SRHR, and thereby assist parliaments to enact national laws based on international human rights norms as set out in the major international and regional instruments;

Recommend greater parliamentary involvement in the ratification and domestication of relevant international and continental instruments relating to women, girls, HIV and sexual and reproductive health rights;

Promise to acquaint ourselves with the legal and policy environment in our countries with regards to HIV and SRHR, and assess the effectiveness thereof with the intent to enact laws aiming at protecting the SRHR of all, with a specific focus on the most vulnerable;

Identify key governance and policy issues which would gradually be incorporated into domestic law regarding HIV and SRHR and explore avenues for enactment of legislation including amendment of different pieces of legislation directly dealing with HIV and comprehensive SRHR;

Commit to review, revise, amend or repeal all laws and regulations, abolish policies and prohibit practices and customs, including cultural and religious practises that have a discriminatory impact on youth especially girls and young women, without distinction of any kind, and ensure that the provisions of domestic legislation comply with international human rights laws and include protection from all harmful practices such as, but not limited to, child marriage, sexual and GBV, and female genital mutilation;

Undertake to harmonise within the region and within the national laws the provisions of legislation dealing with SRHR to ensure the effective implementation of the Resolution 60/2;

The role of parliamentarians

Parliamentarians play multiple roles – they are lawmakers, representatives of their constituents, overseers of government activity and national budgets, and thought leaders and opinion makers. In all of these roles, they can make a critical contribution to meeting the 90-90-90 targets[2] of the Fast-Track approach to end HIV by 2030 and advancing the human rights of people living with HIV, women and girls and members of key populations such as sex workers, men who have sex with men, transgender people and people who use drugs, many of whom experience profound violations of their human rights and an inability to protect themselves from HIV and access prevention, treatment, care and support:[3]

MAHE DECLARATION ON SUSTAINED ENGAGEMENT BY SADC PARLIAMENTS TO IMPLEMENT RESOLUTION 60/2 OF THE COMMISSION ON THE STATUS OF WOMEN ON "WOMEN, THE GIRL CHILD AND HIV AND AIDS" BY THE OF THE REGIONAL WOMEN'S PARLIAMENTARY CAUCUS (RWPC) OF THE SOUTHERN AFRICAN DEVELOPMENT COMMUNITY PARLIAMENTARY FORUM (SADC PF) WHICH MET AT EDEN BLEU HOTEL FROM 5 TO 6 JULY 2017 IN MAHÉ, SEYCHELLES

Mr. President, I beg to move that this Plenary Assembly do adopt the Mahé Declaration by the RWPC to the 41st Plenary Assembly Session of the SADC Parliamentary Forum, laid on the table of the House on the Thursday 13th July 2017.

We, Members of Parliament from the Southern African Development Community (SADC), with the support of the United Nations Agencies and Development Partners and the Civil Society Organisations met in Mahé, Seychelles from 5 to 6 July 2017 prior to the 41st Plenary Assembly Session of SADC PF, for a Regional Women's Parliamentary Caucus devoted to developing a framework for sustained engagement by SADC Parliaments to implement Resolution 60/2 of the Commission on the Status of Women (CSW) entitled "Women, the Girl Child and HIV and AIDS" as defined in the following Declaration:

Recognising that HIV continues to be a major public health and developmental challenge that has a potential to undermine the Sustainable Development Goals (SDGs) and that the epidemic not only causes ill health among populations but also spawns poverty and inequality both of which are an antithesis for sustainable development;

Noting with deep concern that Eastern and Southern Africa has less than 7% of the global population but it contributes close to 50% of new adult infections globally and it is home to more than 19 million people living with HIV, of which more than half are women;

Also noting that the trend in new infections shows an increase in HIV incidence among young people between the ages of 15 and 24 accounting for more than 30% of all new HIV infections and that the epidemic is also characterized by a gender divide - women and girls are increasingly more affected than men and boys with over 70% of new infections occurring among women and girls;

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Pledge to enact laws aimed at improving inclusive access to education at all levels and provide for viable alternatives for the many young people, particularly adolescent girls, who drop out of the formal education system, by facilitating re-entry, revamping informal education and training through standardised certification within and between African countries;

Promise to ensure that in the exercise of the function of approving national budgets adequate allocations are made for SRHR and HIV and AIDS programmes as well as to implement gender-responsive budgeting;

Commit ourselves, individually and collectively, to continue to enhance our knowledge on HIV, SRHR and issues affecting women and girls, and further engage relevant stakeholders (including traditional leaders, faith-based organisations, civil society organisations, development partners and other actors), legislate and exercise oversight on related issues affecting women and girls within our national jurisdictions and act on identified loopholes to ensure universal access to integrated HIV and sexual and reproductive health services and information;

Support institutionalisation of age-appropriate and culturally sensitive comprehensive sexual and reproductive health education for in and out of school young people and youth-friendly health services in order to avert complications and challenges associated with unintended pregnancies, sexually transmitted infections and its consequential impact thereof on the development and wellbeing of young people;

Create an enabling environment by empowering constituencies and strengthening the role of men in improving access to youth friendly sexual reproductive health and reproductive rights services;

Commit to enact laws and advocate for policies that improve access to credit facilities for women, and provide legislation for establishing and institutionalising national Women Funds to increase their access to business capital and thus ensure their social and economic integration and enhance their quality of life and that of their children;

Urge that this Declaration be tabled at the 41st Plenary of the SADC-PF for its deliberation to enhance the implementation of the UN Resolution 60/2 of the CSW, the Girl Child and HIV and AIDS within the SADC Region.

[1] *Available at: http://women.sadcpf.org*

[2] *For more information about the 90-90-90 targets: http://www.unaids.org/en/resources/909090*

- **As representatives of the people**, parliamentarians can make sure they reflect the voices and concerns of all people, including people living with HIV and key populations. They ensure that the voices of those most affected are heard and shape laws, policies and programmes to address the issues of their constituents;

- **As opinion leaders**, parliamentarians can help to combat stigma and discrimination against people living with HIV and key populations; they can encourage open and evidence-informed debates about HIV and SRHR and they can champion rights-based policies and programmes to tackle HIV and enhance access to SRH;

- **As lawmakers,** parliamentarians can develop and enact laws that protect and promote human rights in the context of HIV and SRH and they can ensure that discriminatory laws are repealed or amended. All laws should promote non-discriminatory access to HIV prevention, treatment, care and support and comprehensive sexual and reproductive health care;

- **As overseers of government action**, including national budgets, they can ensure that governments comply with their national, regional and international human rights commitments and that appropriate and sustainable funding is provided for HIV and SRH interventions. They can ensure that all HIV and SRH programmes comprehensively address the needs of people living with HIV, women, girls and key populations.

The 90-90-90 targets and Fast-Track Cities[4]

The Fast-Track Cities is a global partnership between the City of Paris, International Association of Providers of AIDS Care (IAPAC), Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Human Settlements Programme (UN-Habitat), in collaboration with local, national, regional, and international partners and stakeholders.

The initiative was launched on World AIDS Day 2014 in Paris, where mayors from 27 cities in over 50 countries convened to sign the Paris Declaration on Fast-Track Cities (Paris Declaration) committing to accelerate and scale-up their local AIDS responses.

Current Fast-Track Cities includes SADC countries:

- Blantyre and Lilongwe – Malawi
- Dar es Salaam – Tanzania
- Durban and Johannesburg – South Africa
- Kinshasa, Lubumbashi and Mbujimayi – Democratic Republic of Congo (DRC)
- Lusaka – Zambia
- Maputo – Mozambique
- Windhoek - Namibia

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[3] *Adapted from Taking Action Against HIV, Handbook for Parliamentarians No. 15, 2007, http://data.unaids.org/pub/manual/2007/20071128_ipu_handbook_en.pdf*

[4] *For more information about the Fast-Track Cities initiative: http://www.fast-trackcities.org/about*

How to use this manual

This manual is one of several tools available to help strengthen the capacity of parliamentarians to promote and protect human rights in the context of HIV and SRH.

This manual was developed to act as a guide for parliamentarians and to contribute to imparting essential knowledge about critical SRHR, HIV and AIDS issues affecting women and girls in Southern Africa.

The factsheets in this manual contain much of the substance relating to SRH and HIV and AIDS which are being implemented through the project and parliamentarians will benefit immensely by perusing the manual and the tools. The manual is not intended to be exhaustive of SRH, HIV and AIDS issues in Southern Africa, but serves as a useful starting point and is meant to arouse the interest of parliamentarians in advocating for sound HIV and SRHR policies.

Specific aims of the manual

The manual aims to help parliamentarians to:

- Strengthen their understanding of the key HIV, SRHR and human rights issues affecting people in SADC;
- Strengthen their understanding of the evidence-informed and rights-based responses needed to protect SRHR and address HIV;
- Weigh the advantages and disadvantages of responding (or not responding) to critical SRHR and HIV specific challenges through lawmaking;
- Identify opportunities in the parliamentary process to address draft bills or existing legislation that discriminates against people living with HIV, women and girls and/or key populations or that fail to adequately protect their human rights; and SRHR policy loopholes and the need for the legal reforms;
- Explore opportunities to encourage and facilitate citizens' input into SRHR and HIV lawmaking processes and to collaborate with civil society to ensure laws are rights-based and evidence-informed;
- Use practical, interactive exercises and tools such as accountability checklists and guidelines on legislative scrutiny to fulfil their roles; and
- Address stigma and discrimination in their communities and encourage individual health-seeking behaviour and behaviour change.

The manual is made up of two sections:

- **Section 1** is made up of a series of factsheets. These factsheets contain critical information about various aspects of SRHR and HIV; they describe the international and regional human rights obligations of governments and each factsheet ends with concrete examples of what parliamentarians can do to advance the specific SRHR issue.
- **Section 2** contains a set of practical tools that parliamentarians can use and adapt as they work to address SRHR and HIV-related challenges in their countries, parliaments and communities.

2. Background to HIV, SRHR and human rights in SADC

SADC countries remain hardest hit by HIV, with most HIV infections being sexually transmitted or associated with pregnancy, childbirth, or breast feeding. People living with HIV are more likely to require SRH services and those accessing SRH services are likely to be sexually active and therefore require HIV information and services such as HIV testing. HIV and SRHR-related challenges have common drivers such as poverty, harmful cultural norms, gender inequality and marginalisation of vulnerable people.

Citizens of all SADC countries also face persistent challenges in accessing both HIV and SRH-related services. Violations of the right to health and other human rights undermine access to essential and life-saving health services and information for people living with HIV, women and girls, sex workers, gay men and other men who have sex with men, people who use drugs and other vulnerable and marginalised groups. Consequently, the latter are further driven away from the information, services and commodities they need to protect themselves from HIV and other STIs and for women and girls to avoid unwanted or unintended pregnancies.

These factors present a strong argument for stronger linkages between HIV and SRHR programmes.

Reproductive health in SADC

The International Conference on Population and Development (ICPD), held in Cairo in 1994, committed participating governments[5] to achieving universal access to reproductive health care by 2015. Target 5.B of the Millennium Development Goals (MDGs) reinforced that commitment; however, progress towards universal access to reproductive health care has been slow and uneven.[6] By the end of 2015, sub-Saharan Africa lagged behind on many of the most important indicators:

- In sub-Saharan Africa, only 49% of pregnant women had four or more visits with a health provider: the WHO recommends at least four visits;
- There was a large unmet need for contraception in sub-Saharan Africa: nearly one quarter of married women or women in a union reported not having access to family planning and contraception;
- Progress towards reducing the number of adolescent pregnancies has been very slow and adolescent childbearing remains high in Sub-Saharan Africa, at 116 births per 1 000 adolescent girls in 2015. This region has made the least progress since 1990, in both relative terms and absolute numbers;
- While maternal survival has significantly improved since the adoption of the MDGs, women in sub-Saharan Africa continue to die every day from preventable causes. The maternal mortality ratio dropped by 45% worldwide between 1990 and 2013, and in sub-Saharan Africa, a region with some of the worst indicators on maternal death, it fell by 49%. Sub-Saharan Africa and Southern Asia together still accounted for 86% of maternal deaths in 2013.

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[5] *179 countries attended the conference and later adopted the Programme of Action (there were reservations expressed on various aspects of the Programme by several countries).*

[6] *UN, The Millennium Development Goals Report 2015, http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf*

Gender equality

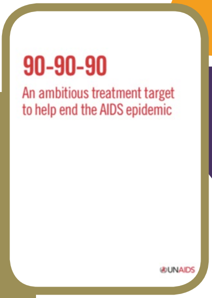
The 2015 MDGs report indicates that significant progress has been made towards achieving MDG 3, promoting gender equality and empowering women, but the report acknowledges that “many gaps remain”. The report notes that it is critical to address gender discrimination, violence against women and girls, women’s unequal opportunities in employment, their limited control of assets and property and the unequal division of unpaid care work, in order to achieve full equality for women and girls.[7]

The 2016 ARASA report on *HIV, TB and Human Rights in Southern and East Africa*, indicates that countries in Southern and East Africa continue to report “high levels of violence against women”.[8]

HIV

Goal 6 of the MDGs aimed to combat HIV and other infectious diseases and set two HIV-related targets: target 6.A to halt and begin to reduce the spread of HIV by 2015, and target 6.B to ensure universal access to treatment by 2010.

The 2017 Global AIDS *Update, Ending AIDS, Progress towards the 90-90-90 Targets*, indicates that progress has indeed been made globally in scaling up access to prevention and Antiretroviral Therapy (ART), resulting in a significant decline in the numbers of new HIV infections and AIDS-related deaths.[9]



90-90-90

An ambitious treatment target to help end the AIDS epidemic

UNAIDS

The 90-90-90 targets

The goal of the targets, set by UNAIDS, is simple: 90% of people living with HIV know their status; 90% of people living with HIV who know their status are on ART; and 90% of people on ART are virally suppressed by 2020. The focus on viral suppression represents an important shift from a focus on the numbers of people accessing ART, and reinforces the importance of viral suppression, not just as an indicator of how well people are doing on treatment, but as an important mechanism to reduce HIV transmission. [10]

The targets were formally launched at the 20th International AIDS Conference in Melbourne, Australia in 2014.

Southern and East Africa, the region most affected by HIV, has also made significant progress towards achieving the 90-90-90 targets: the 2017 Global AIDS Update shows that three out of four people living with HIV in the region know their HIV status; nearly four out of five people living with

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[7] *Ibid.*

[7] *Ibid.*

[8] *ARASA, HIV, TB and Human Rights in Southern and East Africa Report, 2016, http://www.arasa.info/files/3314/8119/1044/ARASA_2016_Human_Rights_report.pdf*

[9] *UNAIDS, Global AIDS Update, Ending AIDS, Progress towards the 90-90-90 Targets, 2017, http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf*

[10] *Ibid.*

HIV who know their status are on treatment; and more than four out of five people on treatment have suppressed viral loads.[11] There are now an estimated 11.7 million people (60%) on ART in the region which represents an almost 300% increase from 2010 when only 23% of people who needed it had access to ART.

These successes should not obscure the disproportionate impact of HIV and the challenges that certain groups, including young women and adolescent girls, gay men and other men who have sex with men, sex workers, people who use drugs and other vulnerable and marginalised groups, experience in accessing prevention, treatment, care and support and protecting their SRHR.

Human rights violations, including violence against women, and criminalisation of various forms of consensual adult sex, stigma and discrimination, must be addressed to create an enabling environment for all people living with HIV to access treatment, care and support, and for all people to have access to information, services and commodities to protect themselves from HIV and other STIs.

International and regional human rights instruments

The right to health has been part of international human rights since the adoption of the Universal Declaration of Human Rights (UDHR) by the General Assembly (GA) of the UN on 10 December 1948. Reproductive health was explicitly recognised as a key aspect of the right to health and other human rights during ICPD in Cairo in 1994, where participating countries recognised that reproductive rights are grounded in human rights already recognised in national laws and international human rights treaties, and governments were therefore obliged to protect reproductive rights under their existing treaty obligations.

Definition of reproductive rights

Reproductive rights are the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. These rights also include the right to the highest attainable standard of SRH and the right of all people to make decisions concerning reproduction, free from discrimination, coercion and violence.[12]

The ICPD Programme of Action also recognised the threat posed by HIV, and expressed concern about the high numbers of women and girls infected and affected by the epidemic.[13] It called on governments to mobilise all segments of society to respond to the HIV epidemic. Since then, the links between HIV and reproductive rights and health have been expanded upon in numerous international documents.

The Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) has the most extensive provisions on sexual and reproductive rights and is the

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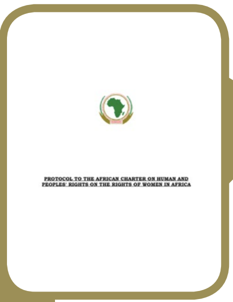
[11] *Ibid.*

[12] *UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994, Para 7.3.*

[13] *Programme of Action, chapter VII.*

first treaty to make explicit the links between HIV and reproductive rights and governments' obligation to protect reproductive rights as part of a response to HIV. It "identifies protection from HIV/AIDS as a key component of women's sexual and reproductive rights." [14] The Protocol, which was adopted by the African Union (AU) in 2003 and entered into force on 25 November 2005, also contains the first expression of a right to abortion (albeit limited) and the first references to HIV in an international treaty.



PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND
PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA

Article 14 of the Maputo Protocol

Art. 14(1)
States Parties shall ensure that right to health of women including SRH is respected and promoted. This includes:

(a) the right to control their fertility;
(b) the right to decide whether to have children, the number of children and the spacing of children;
(c) the right to choose any method of contraception;
(d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
(e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
(f) the right to have family planning education.

Art. 14(2)
States Parties shall take all appropriate measures to:

(a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas:
(b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
(c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother of the life of the mother or the foetus.

SADC framework on SRHR and HIV

SADC has a relatively robust legal and policy framework on both HIV and SRHR. The SADC Protocol on Health contains provisions on HIV, STIs, reproductive and adolescent health.[15] SADC finalised a regional strategy on SRH for the region in 2008, and then developed a SRH business plan in 2011.

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[14] *Centre for Reproductive Rights, The Protocol on the Rights of Women in Africa: An Instrument for Advancing Reproductive and Sexual Rights, 2006, https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_africa.pdf*
[15] *Articles 10, 16 and 17.*

In addition to these key documents, there are a range of regional and sub-regional documents that seek to advance the rights to a healthy sexual and reproductive life for all SADC citizens. The box below lists the key AU and SADC documents on HIV and SRHR.

Regional protocols, frameworks and strategies for HIV and SRHR[16]

- African Union, (2006), Abuja Call for Accelerated Action Towards Universal Access to STI/HIV and AIDS, TB and Malaria Services in Africa.
- African Union (2006), Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework.
- SADC (2003), SADC Maseru Declaration on the Fight Against HIV and AIDS.
- SADC, (2004). SADC Protocol on Health. (Signed in 1999 and entered into force in 2004.)
- SADC, (2008), Sexual and Reproductive Health Strategy for the SADC Region 2006–2015.
- SADC (2010), Harmonised Minimum Standards for the Prevention, Treatment and Management of Tuberculosis in the SADC Region.
- SADC, (2010), Regional Minimum Standards for Harmonised Approaches to the Prevention of Mother-to-Child Transmission of HIV in the SADC Region.
- SADC, (2010), Regional Minimum Standards for Harmonised Guidance on HIV Testing and Counselling in the SADC Region.
- SADC (2010), SADC HIV and AIDS Strategy Framework 2010–2015.
- SADC, (2011), Minimum Package of Services for Orphans and other Vulnerable Children and Youth.
- SADC, (2012), SADC Minimum Standards for Child and Adolescent HIV, TB and Malaria Continuum of Care and Support 2013–2017.
- SADC, (2012), Sexual and Reproductive Health Business Plan for SADC Region 2011–2015. Version 3.
- SADC. Elimination of Mother-to-Child Transmission of HIV (EMTCT) Plan.
- SADC, SADC Regional Conceptual Framework for Psychosocial Support for OVC & Youth.
- UNESCO (2013), Time to Act Now. Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa. UNESCO.


MODEL LAW ON HIV IN SOUTHERN AFRICA

Adopted on 24 November 2008

By the SADC Parliamentary Forum

SADC Parliamentary Forum guidance on SRHR

SADC-PF has developed the SADC Model Law on HIV and AIDS and the SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, which set standards for the region with respect to protection from HIV transmission, protection of key affected populations, collecting of data, confidentiality of patients and SRHR safeguards. The model laws are key in normative standard-setting and serve as yardstick to assess the HIV and SRHR policies in SADC countries. Issues relating to respect, observance and degree of domestication of the model laws across the region are discussed in the annual Plenary Assembly of the SADC-PF.

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[16] *SADC, Overview of the Minimum Standards for the integration of HIV and Sexual Reproductive Health in the SADC region, 2015, https://resourcecentre.savethechildren.net/sites/default/files/documents/sadc_minimum_package_of_services_brief.pdf*

3. Minimum standards for integration of rights based HIV and SRH services in SADC

The SADC *Minimum Standards for the Integration of HIV and Sexual Reproductive Health*, published in 2015, are a tool to support efforts by SADC governments to better integrate SRH and HIV into national laws, policies and programmes.[17] The minimum standards seek to guide SADC countries to address the key challenges of integrating HIV and SRH, including for key populations, and ensure the delivery of key health services to those who need them.

AIDS & Rights Alliance for Southern Africa – Calendar - March 2018

Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region

Definition: integration

Integration is the process of bringing together, in a holistic manner, different kinds of SRH and HIV and AIDS interventions at the levels of legislation, policy, programming and service delivery to ensure access to comprehensive services in an efficient and effective manner.[18]

The first call for integration of SRH and HIV interventions was made at the Cairo ICPD and since then, several global declarations have been made, including the Glion Call to Action on Family Planning and HIV and AIDS in Women and Children (2004) and the New York Call to Commitment: Linking HIV and AIDS and Reproductive Health (2004). The 2001 Declaration of Commitment on HIV/AIDS and both Political Declarations on HIV/AIDS (2006 and 2011) recognised the need to link SRH and HIV.[19]

The most recent (2016) Political Declaration on HIV and AIDS commits governments to:

- ensuring universal access to quality, affordable and comprehensive sexual and reproductive health-care and HIV services, information, and commodities, including women-initiated prevention commodities, including female condoms, pre- and post-exposure prophylaxis, emergency contraceptives and other forms of modern contraceptives by choice, regardless of age or marital status, and ensure that services comply with human rights standards and that all forms of violence, discrimination and coercive practices in health-care settings are eliminated and prohibited;
- reducing the risk of HIV infection among adolescent girls and young women by providing them with quality information and education, mentoring, social protection, and social services, which evidence shows reduce their risk of HIV infection, by ensuring girls' access and transition to secondary and tertiary education and addressing barriers to retention, and by providing women with psychosocial support and vocational training to facilitate their transition from education to decent work.[20]

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[17] *Ibid., Overview of the Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC.*

[18] *IPPF and others, Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: a Generic Guide, 2009, https://www.unfpa.org/sites/default/files/pub-pdf/rapidassessmenttoolsrhlinkages_2009_en.pdf*

[19] *AIDSFonds, Intensify Linkages between HIV and SRHR for maximum impact, 2012 http://stopaidsnow.org/sites/stopaidsnow.org/files/SRHR_IntensifyLinkages_SAA.pdf*

[20] *UN General Assembly, Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight Against HIV and to End the AIDS Epidemic by 2030, 2016, http://www.hlm2016aids.unaids.org/wp-content/uploads/2016/06/2016-political-declaration-HIV-AIDS_en.pdf http://www.hlm2016aids.unaids.org/wp-content/uploads/2016/06/2016-political-declaration-HIV-AIDS_en.pdf*

The minimum standards and the role of parliamentarians

The minimum standards set out a framework to guide SADC countries when programming for services around SRH and HIV and they aim to ensure that all SADC countries meet a set of minimum requirements necessary to attain the regional integration and development aspirations of SADC.[21] They are linked to existing related policies, protocols and programmes.

Guiding principles

The guiding principles define the values that should be applied and upheld by SADC countries in the delivery of integrated SRH and HIV services in the SADC region. These principles are:

- **Human rights centred, gender sensitive and respectful of confidentiality:** SRH and HIV services should be guaranteed and provided for all people in a gender-sensitive and age-responsive manner, which respects the confidentiality of the clients;
- **Involvement and participation:** People living with HIV and AIDS, children, adolescents and youth as well as other key populations and members of the community should be adequately consulted and supported to participate at all levels of SRH and HIV integration programming;
- **Equality and non-discrimination:** Policies, programmes and services should uphold non-discrimination practices in all situations, regardless of HIV status, age, sex, gender, sexual orientation, religion, and sociocultural and economic status;
- **Partnerships and holistic approach:** Ensure the provision of comprehensive information and services for SRH, HIV and AIDS and address the related social and economic determinants through engaging in meaningful partnerships and networks with clearly defined roles and responsibilities;
- **Evidence-based and context-specific:** Implementation of SRH and HIV integration interventions should be guided by evidence and contextualised to country-specific needs, to ensure sustainability and ownership; and
- **Equity and accessibility:** The importance of ensuring universal access to SRH and HIV integrated services by all is recognised, including the particular needs of key populations in the provision of service.

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[21] *Ibid., Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region.*

The role of parliamentarians in ensuring integration of HIV and SRH services

There is an important role for parliamentarians to play in helping implement the minimum standards, both in their own countries and at a regional level. They can ensure that the principles guiding the minimum standards infuse and inform all programming around SRH and HIV, especially when considering budget items in parliament, and they can also help to ensure that there is an enabling legal and policy environment to do so.

The minimum standards specifically recommend that national laws are reviewed to ensure that they promote and do not hinder the integration of SRH and HIV services. Parliamentarians are well placed to initiate and conduct these reviews and can undertake the following actions:

- Conduct an assessment of legal frameworks which impact on access to SRH and HIV services and information for adolescents and youth and key populations, especially men who have sex with men and sex workers;
- Review or develop new legal frameworks based on the findings of the assessment;
- Review or develop new laws and legal frameworks that promote zero-rate taxation on the importation of essential sexual and reproductive health and HIV life-saving commodities;
- Promote the local production of these commodities;
- Review, improve or/and enact new laws that address negative cultural practices that hinder optimal access to SRH and HIV services and information;
- Review, improve or enact new laws to address GBV (including sexual violence) against women, key populations, children, adolescents and youth; and
- Develop or enact laws that ensure access to and utilisation of SRH and HIV services by key populations.[22]

In addition to leveraging their roles as lawmakers, parliamentarians can also support the implementation of the minimum standards in other ways:

- They can ensure that budget allocations include funding for the integration of SRH and HIV services. They can also review and revise existing national and regional budgets on SRH and HIV to ensure integrated interventions;
- They can support community outreach through public hearings, events and meetings to engage and help educate their constituents and create a demand for SRH and HIV services in these communities;
- They can commission or initiate research into key barriers to the integration of HIV and SRH services; and
- They can develop accountability mechanisms to hold member states accountable for the implementation of the minimum standards.

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[22] *Ibid., Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region*

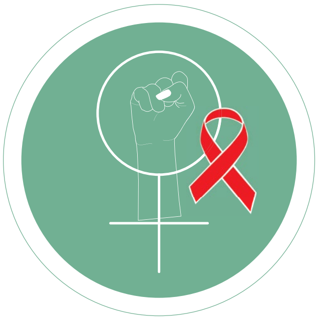
factsheets

Factsheet 1: Sexual and reproductive health and rights of women living with HIV
Factsheet 2: Adolescent girls and young women
Factsheet 3: Child marriage
Factsheet 4: Contraception and family planning
Factsheet 5: Abortion
Factsheet 6: Cervical cancer prevention and screening
Factsheet 7: Key populations
Factsheet 8: Stigma and discrimination in health settings
Factsheet 9: Treatment
Factsheet 10: Prevention
Factsheet 11: Criminalisation of HIV transmission, exposure and non-disclosure

factsheet 1

Sexual and reproductive rights and health of women living with HIV

Women and girls remain at the sharp edge of the HIV epidemic globally: despite the scale-up of treatment and a sharp decline in AIDS-related deaths, 51% of people living with HIV are women. AIDS-related illnesses remain the leading cause of death amongst girls and women between the ages of 15-49. In Southern and East Africa, young women (aged 15–24 years) accounted for 26% of new HIV infections in 2016, despite making up just 10% of the population.[23]



Useful definitions

Domestic violence: refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and/ or controlling behaviours.

Gender-Based Violence (GBV): includes all acts perpetuated against women, men, boys and girls on the basis of their sex which causes or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict. It covers domestic violence, sexual harassment in the workplace, human trafficking and sexual and emotional abuse, to name a few examples. It includes sexual violence.

Sexual violence: is any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.

Sexual and reproductive health services: include availability and access to services that support healthy sexuality and reproduction such as services and support to help women plan their families, including pre-conception support and/or access to contraception as well as attention to infertility and cervical cancer screening and treatment.

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[23] *UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017,http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf*

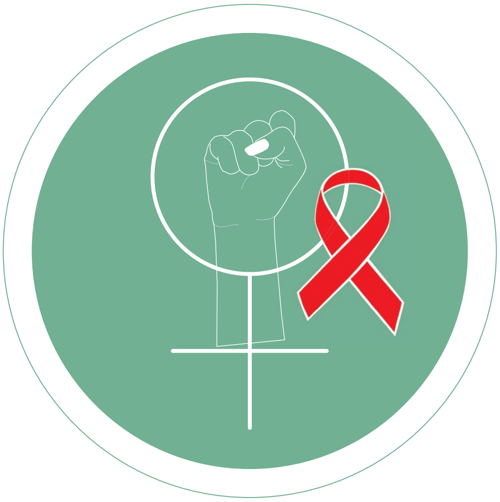
Young women and adolescents and HIV

Young women and girls are increasingly and especially vulnerable to HIV. Three of out four new infections amongst 15–19 year olds in sub-Saharan Africa are amongst girls. HIV is the second leading cause of death for adolescent girls and young women in Africa.[24]

Although the number of new infections is declining, differences between men and women in new HIV infections remain stark: in 2016, new infections amongst young women (aged 15– 24) was 44% higher than for young men of the same age. [25]

For more information on adolescent girls and young women, see factsheet two.

3 out of 4 new infections are amongst girls



Women and girls living with HIV in SADC lack access to comprehensive SRH: there is a large unmet need for contraception, including both male and female condoms; abortion is criminalised in most of Southern Africa; there is limited access to cervical cancer services; discrimination and stigma prevent women and girls from using available services; and young women lack access to CSE. The gaps in HIV prevention, treatment, care and support for women and girls contribute to undermining their SRHR.

Convention on the Elimination of All Forms of Discrimination against Women

Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979

entry into force 3 September 1981, in accordance with article 27(1)

The States Parties to the present Convention,

Noting that the Charter of the United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women,

Noting that the Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex,

Noting that the States Parties to the International Covenants on Human Rights have the obligation to ensure the equal rights of men and women to enjoy all economic, social, cultural, civil and political rights,

Considering the international conventions concluded under the auspices of the United Nations and the specialized agencies promoting equality of rights of men and women,

Noting also the resolutions, declarations and recommendations adopted by the United Nations and the specialized agencies promoting equality of rights of men and women,

Concerned, however, that despite these various instruments extensive discrimination against women continues to exist,

Recalling that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity,

Concerned that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs,

Convinced that the establishment of the new international economic order based on equity and justice will contribute significantly towards the promotion of equality between men and women,

Emphasizing that the eradication of apartheid, all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women,

Affirming that the strengthening of international peace and security, the relaxation of international tension, mutual co-operation among all States irrespective of their social and economic systems, general and complete disarmament, in particular nuclear disarmament under strict and effective international control, the affirmation of the principles of justice, equality and mutual benefit in relations among countries and the realization of the right of peoples under alien and colonial domination and foreign occupation to self-determination and independence, as well as respect for national sovereignty and territorial integrity, will promote social progress and development and as a consequence will contribute to the attainment of full equality between men and women,

Convinced that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields,

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[24] *Ibid.*

[25] *Ibid.*

International and regional human rights obligations

Sexual and reproductive rights are increasingly seen as an integral part of the human right to health, which is recognised by regional and international human rights instruments and is considered as critical and interconnected with all human rights.

Sexual and reproductive rights are increasingly seen as an integral part of the human right to health, which is recognised by regional and international human rights instruments and is considered as critical and interconnected with all human rights.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) prohibits all forms of discrimination against women and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) similarly requires all states in the African region to combat discrimination against women. In addition to the wide-ranging prohibition against discrimination, international and regional human rights obligations also provide that governments should:

- Protect, promote and fulfil sexual and reproductive rights: these rights relate to various human rights, including the rights to life, health and privacy, the rights to education and to equality and non-discrimination. CEDAW states that women have the right to determine the number, spacing and timing of their children and to have access to contraception and the information needed to exercise that right, while the Maputo Protocol includes the right to decide whether to have children, and the number and spacing of pregnancies, as well the right of women to control their fertility and to have access to family planning education. The Protocol also includes the right to be protected against HIV and STIs and a limited right to access abortion.
- Protect, promote and fulfil women's rights to live lives free from violence. The Maputo Protocol obligates States to adopt laws to prohibit all forms of violence against women and punish perpetrators.
- Take steps to eliminate the harmful practices that negatively affect the human rights of women. The Maputo Protocol explicitly recognises this and obligates states to eradicate these practices.

The CSW adopted a resolution on women, girls and HIV that recognises the impact of gender inequality, harmful practices and violence on women and girls' vulnerability to HIV. The resolution calls on government to intensify their efforts to achieve gender equality and eliminate violence against women and girls.

In addition to their legal obligations under international and regional human rights laws, SADC countries have also committed to achieving the Sustainable Development Goals (SDGs), also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. There are several goals that address gender equality and sexual and reproductive health:

3 GOOD HEALTH AND WELL-BEING

SDG 3 promotes healthy lives and well-being for all, at all ages

5 GENDER EQUALITY

SGD 5 presses for the achievement of gender equality and the empowerment of all women and girls

The targets that have been set to measure progress towards achieving these goals by 2030 include ending discrimination against women and girls, eliminating violence against women and girls in the public and private spheres, and all harmful practices. The targets also include ensuring universal access to SRHR.

The 2016 United Nations (UN) General Assembly Political Declaration on Ending AIDS recognises the devastating impact of the HIV epidemic on women and girls, especially in sub-Saharan Africa, and also sets ambitious targets to reduce the number of new HIV infections and ensure universal access to HIV prevention, treatment, care and support.

These include:

- Reaching and sustaining 95% of pregnant women living with HIV with lifelong HIV treatment by 2018;
- Reducing the number of new HIV infections among adolescent girls and young women to below 100 000 per year;
- Ensuring that 90% of adolescent girls and women at high risk of HIV infection access comprehensive prevention services by 2020;
- Ensuring that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV;
- Ensuring that 90% of young people in need have access to sexual and reproductive health services and combination HIV prevention options by 2020;
- Ensuring universal access to quality, affordable and comprehensive sexual and reproductive health care and HIV services, information and commodities for women;
- Eliminating gender inequalities and ending all forms of violence and discrimination against women and girls; and
- Ensuring that 90% of key populations - including female sex workers, transgender women, women who inject drugs and prisoners - access comprehensive prevention services, including harm reduction, by 2020.

Human rights barriers to SRHR for women living with HIV

Gender-Based Violence (GBV)

The WHO estimates that one in three women will experience physical and/or sexual violence at the hands of a partner or ex-partner or sexual violence at the hands of a non-partner.[26] More than 50% of women in six countries in Southern Africa have reported experiencing physical and/or sexual violence.[27] Women living with HIV are additionally vulnerable to violence because of their HIV status.

Gender inequality, discrimination and violence - or the fear of violence - put women, girls and key populations at heightened risk of HIV infection and erodes the benefits of HIV and other health services as they impede the ability of women to insist on safer sex and to use and benefit from HIV prevention, testing and treatment interventions and SRH services. Violence against women is also associated with weakened adherence to Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP) and HIV treatment, including for pregnant women, and it is linked to poor clinical outcomes for women on Antiretroviral Therapy (ART).[28] Studies have also linked domestic violence and even the fear of violence to women's reluctance or inability to negotiate condom usage or to contraceptive use. Among women living with HIV, violence and trauma can lead to lower adherence to treatment, lower CD4 counts and higher viral loads.[29]

GBV also has significant sexual and reproductive health consequences, including unintended pregnancies, unsafe abortions and a high risk of HIV and STIs: women exposed to domestic violence are one and a half times more likely to contract HIV or another STI.

GBV has significant sexual and reproductive health consequences, including unintended pregnancies, unsafe abortions and a high risk of HIV and STIs: women exposed to domestic violence are one and a half times more likely to contract HIV or another STI.

More than 50% of women in six countries in Southern Africa have reported experiencing physical and/or sexual violence.

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[26] WHO, Violence against women: Global Picture, Health Response, http://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf?ua=1

[27] Genderlinks, SADC Gender Protocol 2015 Barometer, 2015

[28] UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017, http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf

[29] UNAIDS, Get on the Fast Track, The life cycle approach to HIV, 2016, http://www.unaids.org/sites/default/files/media_asset/Get-on-the-Fast-Track_en.pdf

Social and economic costs of violence against women

Globally, only 55% of women capable of employment, participate in the labour force, compared to 80% of men. Women are more likely to be poorer than men and have less ability to access and control economic resources in the family and their communities. Violence and the ill health and injuries associated with it can prevent women from working or otherwise participating in the economy, causing them to lose their wages and sometimes their jobs. This in turn can increase poverty for women, their families and society.

The social costs of GBV are also serious: women may become isolated, unable to participate in their regular activities and have limited ability to care for themselves and their children.[30]

Stigma and discrimination

Women and girls living with HIV often face stigma and discrimination when they try to access sexual and reproductive healthcare and make decisions about their health.

Stigma, fears of violence and rejection and abandonment can drive women and girls away from HIV testing, treatment and other sexual and reproductive health care services. It may also inhibit their willingness or ability to disclose their HIV status. Women living with HIV fear that they may be blamed for transmitting HIV to their sexual partners and so may avoid accessing ART in case it exposes their HIV status.

Women and girls living with HIV frequently have little, if any, access to information about sexuality, how they can have satisfying sexual lives and children, if they wish to. Approximately 75% of young women between the ages of 15 and 19 say they do not have the final say in decisions about their health.
For more information about stigma and discrimination in health care settings, see factsheet eight.

Women living with HIV may be coerced or forced to be sterilised, and the criminalisation of same sex, sex work and drug use reinforces stigma and pushes vulnerable women and girls away from critical reproductive and sexual health care.

Criminalisation of HIV transmission, exposure or non-disclosure has sometimes been framed as a way to protect women and girls from HIV infection. Evidence however, shows that criminalisation has a disproportionately negative effect on women and girls: they are more likely to know their HIV status and therefore be blamed for transmitting HIV. Criminalisation does not reduce women's vulnerability to HIV, but harms them and negatively impacts on their rights and public health.

For more information on criminalisation of HIV transmission, exposure and non-disclosure, see factsheet eleven.

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[30] *WHO, Violence against women: Intimate partner and sexual violence against women factsheet, updated 2016, http://www.who.int/mediacentre/factsheets/fs239/en/*

Integration of SRH and HIV

Integration is the process of bringing together, in a holistic manner, different kinds of related SRH and HIV and AIDS interventions at the levels of legislation, policy, programming and service delivery to ensure access to comprehensive services in an efficient and effective manner.[31]

Experts recommend the integration of sexual and reproductive health care with HIV services to increase access to both services for women living with HIV. The integration of these services can ensure that women get access to information and services on family planning, HIV and STIs and cervical cancer and can help women living with HIV make informed decisions about contraception and pregnancy and other aspects of their sexual and reproductive lives.

A project linking SRH and HIV services, supported by UNAIDS and the United Nations Population Fund (UNFPA), formerly the United Nations Fund for Population Activities in seven southern African countries, proved that integrating SRH and HIV services can improve access to the information and services people need to reduce the risk of HIV infection and to safeguard their SRH. At the service delivery level, evidence of the increased uptake of critical SRH and HIV services, efficiencies in service delivery, and experiences of reduced stigma and discrimination were documented.[32]

For more information on cervical cancer screening and prevention, see factsheet six.
For more information on contraception and family planning, see factsheet four.

Harmful practices

Harmful practices such as child and forced marriage, Female Genital Mutilation (FGM) and widow cleansing are rooted in the belief that women and girls are less valuable than men and boys, and they can put the SRH of women and girls at risk, including by exposing them to HIV. Religious and cultural barriers to contraception and abortion lead to unintended and unwanted pregnancies and STIs, including HIV.

Harmful practices such as property grabbing that undermine women's economic rights, including the denial of their land and property rights, can increase poverty, lead to transactional sex and limit women's options when it comes to leaving abusive relationships, increasing their vulnerability to HIV.

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[31] *IPPF and others, Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: a Generic Guide, 2009, http://srhhivlinkages.org/wp-content/uploads/2013/04/rapidassessmenttoolsrhlinkages_2009_en.pdf*

[32] *UNAIDS, UNFPA, Linking sexual and reproductive health and rights and HIV in southern Africa, http://esaro.unfpa.org/sites/default/files/pub-pdf/Regional%20booklet%20final%20-%20Linking%20SRHR%20%26%20HIV%20in%20Southern%20Africa.pdf*

What can parliamentarians do to advance the rights of women and girls living with HIV to SRHR?

Undertake advocacy research: Parliamentarians can initiate research into the sexual and reproductive health needs of women living with HIV, including causes and consequences of violence against women and girls, including women living with HIV, especially the consequences for their SRH. They can investigate whether health care workers have been adequately trained to identify and treat violence against women and offer comprehensive post-rape care to women and girls. They can also investigate whether HIV-related care and sexual and reproductive health care have been integrated and are easily accessible to women and girls living with HIV. Parliamentarians can investigate the availability of CSE for adolescents and young people that includes information and education about contraception, HIV, STIs and safe sex. They can also undertake research to assess the efficacy of programmes to reduce violence against women and advocate for the wider implementation of successful programmes.

Enact and strengthen protective laws: Parliamentarians draft and enact laws that create an enabling environment for women and girls by strengthening laws promoting equality and non-discrimination and protect them from violence: They can ensure that laws:

- Protect, promote and fulfil the right to equality and non-discrimination for all women and girls, including those living with HIV;
- Include an explicit right to SRH;
- Promote equal, non-discriminatory access to a comprehensive package of sexual and reproductive health services for all women, including those living with HIV;
- Promote access to a comprehensive package of post-rape care;
- Criminalise all forms of GBV, including marital rape;
- Promote access to protection services for women and girls, including through access to shelters;
- Promote access to contraception and information about contraception and family planning for women and girls, including appropriate contraception for women and girls living with HIV;
- Prohibit any form of coercion in access to sexual and reproductive health care, including sterilisation;
- Do not criminalise methods of preventing pregnancy;
- Do not criminalise HIV transmission, exposure and/or non-disclosure;
- Do not require spousal or parental consent to access sexual and reproductive health care;
- Respect the right to medical confidentiality for women and girls, including that which relates to HIV status; and
- Promote CSE for adolescents and young men and women.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance equality for women and ensure that they can exercise their SRHR. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance. Parliamentarians can encourage governments to develop national plans of action on violence against women. They can monitor and hold government ministries accountable for reporting on their progress and achievements to achieve goals to protect the SRHR of women living with HIV. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to advance universal access to SRH and eliminate GBV. They can analyse budget allocations for SRH and HIV-related services to assess that programmes will reach women living with HIV and other vulnerable and marginalised women. They can encourage various ministries (e.g. health, education, justice) to budget for relevant programmes and to ensure that human rights are fully integrated into programmes on contraception, and that they are appropriately costed to ensure implementation.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the unacceptability of violence against women and the importance of SRHR for women living with HIV. By speaking out, parliamentarians can help to build an enabling environment for women and girls to seek protection from violence and access to SRH, including in the aftermath of violence. They can advocate for the rights of women living with HIV and frame access to SRH as a human rights issue. They can attend events and speak out to frame GBV as a human rights issue. They can use international or national human rights days, including the 16 Days of Activism to End Violence against Women (25 November – 10 December), International Women's Day (8 March) and World AIDS Day (1 December) to increase awareness of violence against women and girls, including those living with HIV, the links between HIV and violence against women and SRHR. They can also work within Parliament and in parliamentary forums and networks, to raise awareness of these issues amongst fellow parliamentarians. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with civil society organisations (CSOs), including those led by women living with HIV, health care workers and other groups working on women's rights, violence against women, HIV and sexual and reproductive rights to increase awareness, understanding and information on women and girls' higher risk of HIV, the need for access to sexual and reproductive health care, including for women and girls living with HIV, and violence against women. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on all forms of violence against women and harmful practices, HIV, prevention efforts and barriers to women and girls exercising their sexual and reproductive rights. Parliamentarians can play an important role in ensuring that the voices of women and girls, including those living with HIV, are included in discussions about their lives, and help to empower women and girls living with HIV to advocate on their own behalf.

Represent their electorate: Parliamentarians can engage with key stakeholders within communities – women living with HIV, health care workers, parents, traditional leaders and religious leaders, to increase awareness of the human rights. In particular, parliamentarians can ensure they include the voices of girls and women living with HIV at the centre of these conversations.

Work with the media: Parliamentarians should engage with and reflect the concerns of all their electorate, including women living with HIV. Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on SRHR of women living with HIV, including GBV against women living with HIV. They can encourage the media to write stories that do not reinforce stigma and discrimination against women living with HIV and create awareness of the sexual and reproductive rights of all women, including those living with HIV.

References

Office of the High Commissioner on Human Rights, resource page on sexual and reproductive health and rights
http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx

UNAIDS, When Women Lead, Change Happens, Women Advancing the End of AIDS, 2017
http://www.unaids.org/sites/default/files/media_asset/when-women-lead-change-happens_en.pdf

WHO: Violence against women: Global Picture, Health Response
http://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf?ua=1

Adolescent girls and young women

In 2015, there were 1.2 billion youth (between the ages of 15 and 24) globally. While the number of young people has stabilised, and is beginning to decline in most parts of the world, the number of young people in Africa is still growing rapidly. In 2015, 226 million youth aged 15-24 lived in Africa, accounting for 19% of the global youth population.[33]

Young people, especially girls and young women, in sub-Saharan Africa face many challenges in exercising their sexual and reproductive rights: girls and young women are at higher risk of HIV and in 2016, global new infections amongst young women between the ages of 15 and 24 were 44% higher than young men of the same age. In Southern and East Africa, young women accounted for 26% of new infections, despite making up just 10% of the population.[34]

Girls and young women are also at risk of unwanted, unintended pregnancy, unsafe abortion and the health consequences that follow from these. Approximately 16 million girls between the ages of 15 and 19 and 1 million girls below the age of 15, give birth every year, mostly in low- and middle-income countries. Three million girls undergo unsafe abortions annually.

For more information about contraception and family planning, see factsheet four.

For more information about abortion, see factsheet five.

Young women and girls' vulnerability to HIV and their lack of access to SRH is directly linked to gender inequality, harmful gender norms and structures that limit their ability to fully realise their sexual and reproductive rights.

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[33] *UNAIDS, Ending AIDS, Progress towards the 90 – 90 -90 targets, July 2017, http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf*

[34] *WHO, Adolescent pregnancy factsheet, 2014, http://www.who.int/mediacentre/factsheets/fs364/en/*

Useful definitions

Adolescence: the WHO defines adolescence as a period of life with specific health and developmental needs and rights. It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles.[35]

Adolescent: the WHO defines an adolescent as someone between the ages of 10 and 19.

Adolescent and youth-friendly health services: these are health services that are both responsive and acceptable to the needs of adolescents and youth, and which are provided in a non-judgmental, confidential and private environment, in times and locations that are convenient for adolescents and youth.

Comprehensive Sexuality Education (CSE): this refers to provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality.[37]

Modern contraceptive methods: the pill, injectable, IUDs, implants, female and male condoms.

Traditional contraceptive methods: abstinence (abstaining from sex altogether or abstaining from vaginal sex), withdrawal (removing the penis from the vagina prior to ejaculation). These methods do not reliably prevent pregnancy and they cannot prevent STIs.

Unmet need for modern contraception: these are women who want to prevent pregnancy but who do not use contraception or use traditional contraceptive methods. They may not use contraception for many different reasons: they may not have access to information or the commodities; they may not be able to afford contraception; they may be pressurised by sexual partners or family members not to use contraception and they may coerced into sex without contraception.

Young people: the WHO's definition of young people, people between the ages of 10 and 24, overlaps with its definition of adolescents.

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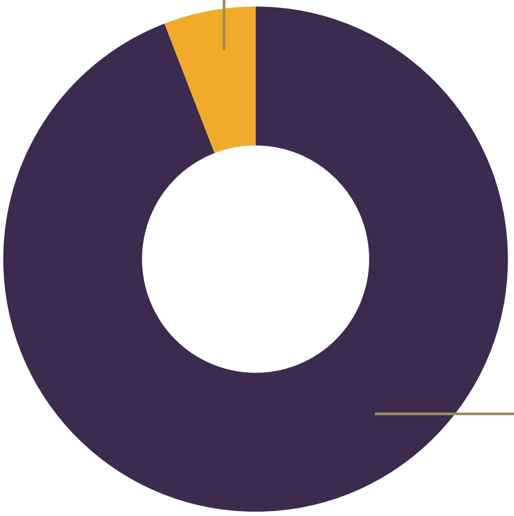
[35] *WHO, Adolescent development, http://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/*

[37] *UNESCO, International Technical Guidance on Sexuality Education: An evidence informed approach for schools, teachers and health educators, http://unesdoc.unesco.org/images/0018/001832/183281e.pdf*

Three million girls undergo unsafe abortions annually

Young women and girls are frequently unable to determine how and when they have sex and whether they get pregnant. Married girls in particular often cannot choose whether they want to get pregnant and are pressurised by spouses and in-laws to have children as soon as possible. Young women are socialised not to be assertive about their sexuality and sexual needs, further reducing their ability to negotiate sex.

1 million girls below the age of 15, give birth every year



16 million girls between the ages of 15 and 19 give birth every year

International and regional human rights obligations

SADC countries have ratified international and regional human rights treaties that protect the rights of young women and girls to reproductive rights and health, including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the African Charter on Human and Peoples' Rights and the Convention on the Rights of the Child (CRC). This includes access to health care, health-related information and to make decisions about the number and spacing of children.

The Maputo Protocol includes the right to choose a method of contraception, to have access to family planning education and to be protected against HIV and STIs. It explicitly includes a limited right to medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the woman or the life of the woman or the foetus.

The CRC states that children have a right to health-related information that includes information about how to prevent early pregnancy. The SADC Gender and Development Protocol also states the girls should have equal access to education, information, services and facilities on SRHR.

The Committee on Social, Cultural and Economic Rights has stated that access to reproductive and sexual health care should include "a wide range of contraceptive methods, such as condoms and emergency contraception, medicines for abortion and for post-abortion care, and medicines, including generic medicines, for the prevention and treatment of sexually transmitted infections and HIV".
Both the CRC committee and the CEDAW committee have recognised the rights of adolescents to contraceptive information and services. The CEDAW committee has urged countries to decriminalise abortion to ensure that women and girls have access to safe abortion and post-abortion care.

In 2016, the CSW adopted resolution 60/2 on women, girls and HIV. The resolution recognised that violence, discrimination and harmful practices are key contributing factors to the spread of HIV amongst women and girls and calls on states to intensify efforts to achieve gender equality.

In addition to their legal obligations under international human rights laws, SADC countries have also committed to achieve the SDGs, also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. Target 3.7 aims to ensure universal access to sexual and reproductive health care services, including family planning education and information, by 2030.

The 2016 Political Declaration for Ending AIDS includes a pledge to eliminate gender inequalities and end all forms of violence and discrimination against women and girls. The Declaration includes targets for reducing the number of new HIV infections among adolescent girls and young women to below 100 000 per year, ensuring that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and that 90% of young people in need have access to sexual and reproductive health services and combination HIV prevention options by 2020.
SADC has recently developed guidelines to assist member states on target-setting, critical analyses and investment planning for HIV prevention for adolescent girls, young women and their sexual partners.

Human rights barriers to sexual and reproductive health and rights and the consequences for young women and girls

Discriminatory laws

Many SADC countries have laws in place that create barriers to adolescent SRHR: [38]

- Few SADC countries have explicit consent to sex ages set out in their legislation.[39] This makes it difficult for both adolescents and policy makers to determine what the minimum legal age of consent is. Where the legal age of consent to sex is not specified by law, adolescents and young people often encounter barriers to accessing services related to SRH.
- Not all SADC countries have set minimum marriage ages in their laws and in many countries, there is a conflict between civil and traditional laws.

For more information about child marriage, see factsheet three.

- The majority of SADC countries do not have laws that specify the age at which adolescents can independently consent to medical treatment, including HIV and SRH; this includes access to contraception, HIV counselling and testing and abortions. The lack of clarity about when adolescents are able to make decisions on their own behalf creates a significant barrier to access to services.

Research shows that exposure to violence during childhood and adolescence increases HIV-related risk-taking behaviour among adolescent girls and young women.

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[38] *UNFPA, Harmonising the Legal Environment for Adolescent Sexual and Reproductive Rights and Health, a review of 23 countries in East and Southern Africa, 2017, http://www.up.ac.za/media/shared/1/ZP_Files/unfpa-esa-ro-laws-and-policy-review-on-asrhr-2017.zp119762.pdf*
[39] *Ibid.*

Gender-Based Violence (GBV)

The WHO estimates that 150 million girls experience forced sex or other forms of sexual violence annually and for many, their first experience of sex is coerced.[40] Research shows that domestic violence increases the risk of HIV transmission and unwanted pregnancies.

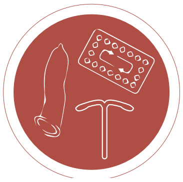
Research also shows that exposure to violence during childhood and adolescence increases HIV-related risk-taking behaviour among adolescent girls and young women and in some regions, women who experience violence are 50% more likely to acquire HIV than women who do not.

Lack of sexual autonomy and informed decision making

Young women and girls are frequently unable to determine how and when they have sex and whether they get pregnant. Married girls in particular often cannot choose whether they want to get pregnant and are pressurised by spouses and in-laws to have children as soon as possible. Young women are socialised not to be assertive about their sexuality and sexual needs, further reducing their ability to negotiate sex.

Criminalisation of consensual adolescent sex

Some SADC countries criminalise consensual adolescent sex, creating significant barriers to the access to SRH. Criminalisation not only stigmatises adolescent sexuality; it also undermines the recognition of the evolving capacities of adolescents as set out in various international human rights instruments including the CRC. States may criminalise sex between an adult and a child with a view to protecting children until they reach the age of adulthood.



Limited access to contraception and abortion

The large unmet need for contraception amongst girls and young women in Africa leads to unwanted and unintended pregnancy, unsafe abortions and negative health consequences. Complications related to early pregnancy and child birth are one of the leading causes of death amongst young women, and babies born to adolescent mothers face greater health risks than those born to older women. Adolescent girls are also at higher risk of obstetric fistula.

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[40] *UNFPA, Motherhood in Childhood. Facing the Challenge of Adolescent Pregnancy, 2013, http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf*

Child marriage and adolescent pregnancy[41]

Ending child marriage is a critical component of addressing adolescent pregnancy. Regions with the highest prevalence of child marriage, such as sub-Saharan Africa, also have very high rates of adolescent pregnancy and HIV rates amongst young women. Married girls have both the lowest use of contraception and the highest levels of unmet need.

For more information on child marriage, see factsheet three.

Restrictive laws on abortion in many SADC countries prevent young women and girls from accessing safe abortions and even where abortion is legal, adolescents struggle more than adult women to access abortion and post-abortion care. In sub-Saharan Africa, approximately 36 000 women and girls die each year from unsafe abortion and adolescents are more vulnerable to complications from unsafe abortion than adult women.[42]

Adolescent girls who get pregnant are less likely to complete their education and unwanted pregnancy and subsequent motherhood can help to perpetuate poverty. Preventing unwanted adolescent pregnancy greatly benefits girls and their families, but it also has significant advantages for communities and society.[43]

Economic consequences of adolescent pregnancy[44]

Adolescent girls who can delay pregnancy are more likely to stay in school and pursue income-earning possibilities. The World Bank's research shows that investing in programmes that empower girls, including through allowing them to complete their education, do not only benefit girls themselves, but the economy. Their research shows the lifetime opportunity cost related to adolescent pregnancy - measured by the mother's lost annual income over her lifetime - ranges from 1% of annual gross domestic product (GDP) in China to 30% of annual GDP in Uganda. As an example, the World Bank study illustrates the opportunity costs associated with adolescent pregnancy and dropping out of school in Kenya: if all 1.6 million adolescent girls in Kenya finished secondary school, and if the 220 098 adolescent mothers there were employed instead of having become pregnant, the cumulative effect could have added $3.4 billion to Kenya's gross income every year.

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[41] *UNFPA, Motherhood in Childhood. Facing the Challenge of Adolescent Pregnancy, 2013, http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf*

[42] *Ibid.*

[43] *Guttmacher, Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-adolescents-report.pdf*

[44] *UNFPA, Motherhood in Childhood. Facing the Challenge of Adolescent Pregnancy, 2013, http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf*

While the economic costs associated with adolescent pregnancy are significant, the World Bank study emphasises that this analysis underestimates the true cost of not investing in girls. The study looks only at lost productivity in the labour market and does not estimate costs incurred to women's health, the possible implications for the child's future productivity as indicated by studies that show that children of adolescent mothers have lower school enrolment rates, and the social costs of unwed adolescent mothers. The true costs, which include lower health status of the children of these girls, lower life expectancy, skill obsolescence of jobless girls, less social empowerment, and so forth would increase the cost estimates many-fold.

Limited access to adolescent-friendly sexual and reproductive health care and information

The majority of SADC countries do not have laws and policies that clearly set out the rights of adolescents to access sexual and reproductive health services.[45] There are too few health facilities that seek to meet the specific SRH needs of adolescents and adolescents, and young women who do seek sexual and reproductive health care are often stigmatised by health care workers and experience discrimination and violations of their right to medical confidentiality and other rights.

For more information about stigma and discrimination in health settings, see factsheet eight.

Adolescent girls also struggle to access information about their sexual and reproductive health needs. For example, in sub-Saharan Africa, only 26% of girls have accurate information about HIV. Young women and girls also lack access to information to help them make informed decisions about how to delay or prevent pregnancy and reduce their risk of STIs, including HIV. There is a critical lack of CSE at schools and programmes that target out of school youth. These gaps lead to high rates of pregnancy, unsafe abortion, HIV and STIs amongst girls and young women.

Lack of access to services to support adolescent girls and young women living with HIV

There are almost no services in SADC countries that target the SRH needs of adolescent girls and young women living with HIV, including giving them accurate information about how to enjoy sex safely, providing them with access to male and female condoms and supporting them to safely discuss their HIV status with sexual partners and their families.[46]

[45] *UNFPA, Harmonising the Legal Environment for Adolescent Sexual and Reproductive Rights and Health, a review of 23 countries in East and Southern Africa, 2017, http://www.up.ac.za/media/shared/1/ZP_Files/unfpa-esaro-laws-and-policy-review-on-asrhr-2017.zp119762.pdf*

[46] *See for example: Jana, M and others, Challenges to youths accessing sexual and reproductive health information and services in Southern Africa: a review of qualitative research in seven countries, 2012, http://www.sexrightsafrica.net/wp-content/uploads/2016/12/Challenges-to-Youths-Accessing-Sexual-and-Reproductive-Health-Information-and-Services-in-Southern-Africa-A-Review-of-Qualitative-Research-in-Seven-Countries.pdf*

What can parliamentarians do to advance the rights of women and girls living with HIV to SRHR?

Parliamentarians can champion goals and strategies to reduce new HIV infections amongst adolescent girls and young women, ensure that those living with HIV have access to treatment, care and support, and ensure the SRHR of adolescent girls and young women are protected in all laws, programmes and policies.

Undertake advocacy research: Parliamentarians can initiate research into the barriers to SRHR for young women and adolescent girls, including the lack of adolescent-friendly health facilities, obstacles to girls enrolling and remaining in secondary school, prevalence of sexual coercion and sexual violence against women and girls, including in schools, and availability or lack thereof, of CSE for in and out of school youth. Parliamentarians can also initiate or support research to quantify the costs associated with adolescent pregnancy in their country.

Enact and strengthen protective laws: Parliamentarians can draft and enact laws eliminating discrimination against adolescent girls and young women and supporting access to SRHR. They can ensure that laws:

- Set the minimum marriage age for boys and girls at 18 years and eradicate laws that allow for child betrothal;
- Set a minimum legal age for consent to sex that is the same for boys and girls (that aligns with the age of consent to sexual and reproductive health care);
- Criminalise marital rape and all forms of sexual violence against adolescent girls and young women;
- Promote equal access to education for girls;
- Promote CSE for adolescents and young men and women; and
- Do not require parental consent for access to information and services related to contraception, STIs, HIV counselling and testing, ART and abortion and post-abortion care for adolescents below the age of 18 if the health care worker is of the view that the adolescent is able to make an informed decision about the service required. Parliamentarians can ensure that emergency measures are available where parental consent cannot be obtained.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance equality for adolescent girls and young women and promote their rights to SRH. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance. Parliamentarians can encourage governments to develop national plans of action, with clear targets, milestones, indicators and allocated budgets, to achieve SDG Target 3.7 on ensuring universal access to sexual and reproductive health care services and SDG Target 5.3 on ending child marriage, by 2030. They can monitor and hold government ministries accountable for reporting on their progress towards achieving these goals.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to advance universal access to SRHR for young women and adolescent girls. They can analyse budget allocations for SRH and HIV-related services to assess that programmes will reach adolescent girls and young women. They can encourage various ministries (e.g. health, education, justice) to budget for relevant programmes.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on advancing equality for young women and adolescent girls and protecting their SRHR and, in particular, helping combat negative and undermining attitudes towards girls' autonomy and adolescent sexuality. They can reinforce the importance of girls' education. They can attend events and deliver speeches to frame access to SRH and rights for adolescents and young women as important human rights issues. They can use international or national human rights days, including International Women's Day (8 March) and the International Day of the Girl Child (11 October) to increase awareness about the harms of adolescent pregnancy and the health consequences of unwanted pregnancy and unsafe abortion. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians on the causes and impact of adolescent pregnancy. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with CSOs, health care workers and youth led groups to increase awareness, understanding and information on SRHR for adolescents and young women. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on the barriers to sexual and reproductive health care for young women and girls, gender inequality, sexual violence against women and girls, the prevalence of child marriage in the country, the impact it has on girls, and the challenges within the legal framework. They can empower young women and adolescent girls to advocate on their own behalf by inviting them to participate in these meetings. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can play an important role in ensuring that the voices of girls and young women are included in discussions about their lives.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including young women and adolescent girls. They can engage with key stakeholders within communities – young people, teachers, parents, traditional leaders, religious leaders and health workers, to increase awareness to advance the SRHR of young women and girls and the actions needed to fulfil these rights. In particular, parliamentarians can ensure they include the voices of girls and young women at the centre of these conversations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on adolescent sexuality and SRHR. They can encourage the media to write and report on stories that portray girls and young women in ways that support and protect their human rights.

References

Guttmacher, Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in sub-Saharan Africa, 2016
https://www.guttmacher.org/fact-sheet/adding-it-meeting-contraceptive-needs-of-adolescents-sub-saharan-africa

UNAIDS, Get on the Fast Track, The life cycle approach to HIV, 2016
http://www.unaids.org/sites/default/files/media_asset/Get-on-the-Fast-Track_en.pdf

UNFPA, Motherhood in Childhood. Facing the Challenge of Adolescent Pregnancy, 2013
http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf

factsheet 3

Child marriage

Child marriage is a formal marriage or informal union where one or both parties are below 18 years old. In sub-Saharan Africa, 39% of girls are married before they reach 18 and three SADC countries, Madagascar, Malawi and Mozambique, are numbered amongst the 20 countries with the highest rates of child marriage globally. Boys are also married as children, but girls are disproportionately affected and are seven times more likely to be married as children.

Child marriage has far-reaching, negative consequences on the lives of girls and later, women: it undermines their human rights to education, reproductive health, to live lives free from violence and entrenches gender inequality. This in turn impacts on society and undermines the ability of countries to achieve development goals.

Useful definitions

Legal age of consent: this usually refers to the age when a person can legally consent to sex.

Child: The CRC and the Africa Charter on the Rights and Welfare of the Child define a child as a person below the age of 18.

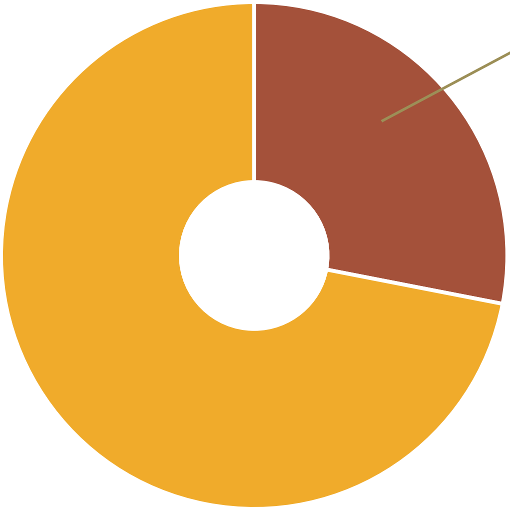
Early marriage: this term is often used interchangeably with child marriage, but it can also refer to marriage in a country where a child legally attains majority upon marriage, even when they are below the age of 18 when the marriage takes places.

Forced marriage: is a marriage that takes place without the full and free consent of one or both of the parties or when one or both of the parties is unable to leave the marriage.

Marriage: is the union of persons by means of statutory, religious or customary law or practice or by means of a verbal agreement.

Minimum marriage age: is the legal age at which someone can lawfully consent to marriage. Minimum marriage ages can be found in both statutory and customary laws, and there is an evolving international consensus that the minimum marriage age should be 18.

Child marriage has far-reaching, negative consequences. Research shows that it limits or ends girls' education, undermining their ability to earn a living and leaving them economically dependent on their husbands and in-laws. It also makes them increasingly vulnerable to violence and sexual abuse and has long term and sometimes chronic health consequences related to early pregnancy and child-birth.



In sub-Saharan Africa, 39% of girls are married before they reach 18

Drivers of child marriage:

- Poverty
- Customary practices and religious beliefs
- Lack of access to primary and secondary education
- Poor commitment to end child marriage

International and regional human rights obligations

Many SADC countries have ratified international and regional human rights instruments that oblige them to take steps to protect and promote the rights of girls. These include their rights to equality, non-discrimination, education, health and protection from violence, exploitation and abuse, as well as free and full consent to marriage, to choose one's spouse and to access to information.

International and regional human rights instruments include rights that support efforts to end child marriage:

- The African Charter on the Rights and Welfare of the Child, the Protocol on the Rights of Women in Africa (Maputo Protocol) and the SADC Protocol on Gender and Development state that the minimum age of marriage should be 18 years. The African Charter on the Rights and Welfare of the Child defines child marriage and the betrothal of girls and boys as a harmful social and cultural practice and the Maputo Protocol places obligations on states to eradicate harmful practices that undermine the human rights of women;
- The CRC Committee has taken a clear position on 18 as the minimum marriage age, regardless of parental consent; and
- The CEDAW recommends that women and men be given equal rights to marry only with free and full consent, and the Maputo Protocol states that no marriage should take place without the free and full consent of both parties.

In addition to their legal obligations under international human rights laws, SADC countries have also committed to achieve the SDGs, also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. Target 5.3 of the SDGs commits Member States to "eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations" by 2030.

AU Campaign to end child marriage: #EndChildMarriageNow

In 2014, the AU launched a campaign to end child marriage. The campaign encourages African governments to address the detrimental consequences of child marriage and to develop laws, policies and actions that protect girls' human rights.

By August 2017, the Democratic Republic of Congo (DRC), Madagascar and Malawi had launched national campaigns to end child marriage.

The SADC-PF Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, adopted in 2016, provides guidance to SADC countries on the ideal laws and policies to end child marriage and to protect those already in a child marriage. It recommends that the age of consent to marriage be 18 years, without exception. It also recommends that countries enact laws and policies to:

- Prohibit child betrothals;
- Provide for legal aid to victims of child marriage and custody and maintenance of children of prohibited marriages;
- Provide for the legitimacy of children born of child marriages;
- Provide for programmes to delay marriage;
- Provide for places of safety for victims of child marriage;
- Provide for awareness on children's rights and the consequences of child marriage;
- Provide for the establishment of an anti-child marriage fund to enable implementation of the laws; and
- Provide for effective enforcement of the laws.

Child marriage in SADC

Various SADC countries have set a minimum marriage age in their laws. Not all of these are consistent with the internationally recommended minimum age of 18 years and in some cases, these laws discriminate between boys and girls, with a lower minimum age provided for girls. In many countries, customary and religious laws that allow for marriage at different ages may conflict with national laws, which are often not well enforced.

Country	Child marriage prevalence[47] in SADC countries[48]	Minimum marriage age[49]	Exceptions
Angola	No data available	18	The law allows for exceptions: boys may marry at 16 and girls at 15 with the permission of a person having authority over the minor.
Botswana	No data available	18	
Democratic Republic of Congo	37%	18 (boys) 15 (girls)	
Lesotho	19%	21	The law allows for girls to marry at 16 and for boys to marry at 18 with the written permission from the Minister.
Madagascar	41%	18	
Malawi	46%	18	
Mauritius	No data available	18	Minors aged 16 or more can marry with the consent of their parents
Mozambique	48%	18	Minors aged 16 or more can marry with the consent of their parents
Namibia	7%	18	Individuals under the age of 18 may marry with the written permission of the Minister or any staff member in the Public Service authorised by the Minister.
Seychelles	No data available	18 (boys) 15 (girls)	
South Africa	7%	18 (boys) 15 (girls)	Minors below the marriage age may marry with the permission of their parents or the Commissioner of Child Welfare. They also need the permission of the Minister of Home Affairs
Swaziland	7%	18	Girls may marry at 16 with parental consent and approval from the Ministry of Justice. The government recognises civil marriages as well as marriages under customary law. Under customary law, marriages are permitted for girls as young as 13.
Tanzania	37%	18 (boys) 14 (girls)	
Zambia	31%	21	Minors aged 16 or more can marry with the consent of their parents. Customary law allows girls to marry when they reach puberty.
Zimbabwe	34%	16 (girls) 18 (boys)	In 2016, the Constitutional Court declared child marriage to be unlawful and set 18 as the minimum marriage age for boys and girls.

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[47] The prevalence of child marriage is calculated as the percentage of women between the ages of 20 – 24 years who were first married or in union before they were 18 years old. This is the measure developed and used by UNICEF in its 2016 State of the World's Children report.

[48] The information in this table was taken from the Girls Not Brides website: www.girlsnotbrides.org

[49] This information was taken from the Girls Not Brides website: www.girlsnotbrides.org

Drivers of child marriage

Child marriage is caused and exacerbated by various factors:

Poverty: Poverty is a significant cause of child marriage, and girls from poor families are almost twice as likely to marry early than those from wealthier families. Marrying a girl may help a family to reduce household expenses because they have one less mouth to feed, or gain income when dowry is paid by the groom's family. Some families believe they can provide a better future for their daughters by marrying them into wealthier families. Many girls may see marriage as their only pathway out of poverty.

Customary practices and religious beliefs: Child marriage may be part of a community's culture or religious practice that has taken place for hundreds of years. Gender inequality, patriarchy and social expectations about the roles of women and girls in society, often shaped by tradition, and practices such as the payment of dowry, help to perpetuate child marriage.

Lack of access to primary and secondary education: Access to education appears to protect girls from child marriage, giving them skills and knowledge and more power to choose to delay marriage. Girls with no education are three times more likely to marry than those with secondary or higher education.

Poor commitment to end child marriage: In some countries, there is little commitment from national and traditional leaders to end child marriage. There are frequently gaps in legal and policy frameworks that limit protection and undermine efforts to eradicate child marriage, including no or inconsistent legal definitions of a child, no or low minimum marriage ages, no mandatory birth and marriage registration and domestic and sexual violence laws that fail to criminalise marital rape. Where there are laws against child marriage, these are not well known or enforced, and may conflict with customary laws, which allow child marriage.

Harmful consequences of child marriage

Child marriage has far-reaching, negative consequences. Research shows that it limits or ends girls' education, undermining their ability to earn a living and leaving them economically dependent on their husbands and in-laws. It also makes them increasingly vulnerable to violence and sexual abuse and has long term and sometimes chronic health consequences related to early pregnancy and child-birth.

Health: Child marriage has devastating consequences for girls' SRH. Pregnancy-related complications are among the leading causes of death for girls aged 15 to 19 and babies born to girls under 20 in low- and middle-income countries are 50% more likely to be still-born or to die within a few weeks. Girls who marry early become sexually active at a time when they may have limited information or power to make decisions about their SRH and unprotected sex places them at increased risk of HIV, STIs and unwanted pregnancy.

For more information about contraception and family planning, see factsheet four.

Education: Girls are frequently forced to leave school when they get married or become pregnant because of marital or domestic demands on their time or because their families do not allow them to continue their education. Married or pregnant girls and young mothers are often stigmatised by their peers, teachers and/or school officials. In some SADC countries, married girls and young mothers may be legally excluded from school.

Gender-based violence (GBV): Child marriage puts girls at risk of sexual, physical and psychological violence. Girls who marry early are more likely to experience domestic abuse and to report that their first sexual experience was forced. They are often in an unequal power relationship, with little ability to assert themselves against their older husbands. Research also shows that girls in marriages with a large age gap between the girl and her husband are more vulnerable to domestic and sexual violence.

Economic costs of child marriage[50]

Recent research shows that child marriage has a substantial impact on women's potential earnings and productivity, mainly because child marriage disrupts their education and reduces their earnings in adulthood. Countries will lose on average 1% of their earnings as a result of child marriage.

The same research shows that ending child marriage could add approximately $4 trillion to the global economy. In addition to the economic benefits, ending child marriage would also transform the lives of millions of girls and their communities.

What can parliamentarians do to help end child marriage?

The SADC Model Law on Eradicating Child Marriages and Protecting Children Already in Marriage sets important standards for the protection of children in Southern Africa. The Model Law sets out legal norms which may be used as inspiration for lawmaking. Its focus on the particular circumstances of the African region, such as the need to register all marriages, prohibit betrothals, harmful customary practices, and the anti-child marriage fund make it a unique guiding document for the SADC region and beyond.

ICWR and others, Economic Impacts of Child Marriage: Work, Earnings and Household Welfare Brief, 2017, http://www.costsofchildmarriage.org/?utm_source=Girls+Not+Brides+Newsletters+Mailing+List&utm_campaign=47275c9738-EMAIL_CAMPAIGN_2017_06_29&utm_medium=email&utm_term=0_a83e20c2e1-47275c9738-397967561

Undertake advocacy research: Parliamentarians can initiate research into the prevalence of child marriage in their countries. They can call for research to investigate the prevalence, causes and impact of child marriage; the laws, customs and practices around child marriage; gaps and challenges within national laws and policies and best practices to respond to and eradicate child marriage.

Enact and strengthen protective laws: Parliamentarians can draft and enact laws that help to end child marriage. They can use the SADC-PF Model Law on Ending Child Marriage as a basis to call for the development or reform of laws, with a focus on the following:

- Ensure that laws set the minimum marriage age for boys and girls at 18 years. Where the law allows for exceptions, children below the age of 18 should only be allowed to marry with the permission of a judge or a judicial process to ensure that both parties have consented to the marriage;
- Ensure that laws governing marriage require full and free consent to marriage by both parties and proof of age of both parties;
- Ensure that laws provide for the compulsory registration of births and marriages;
- Ensure that there are no inconsistencies between statutory and customary laws, with regard to the minimum marriage age;
- Promote equal, non-discriminatory access to SRH services and information, including information on HIV-related services, for adolescent girls and boys and young women and men;
- Respect the right to medical confidentiality for girls, both married and unmarried; and
- Promote CSE for adolescents and young men and women, including information about contraception and HIV prevention.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with international and regional human rights commitments to end child marriage. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about the causes and impact of child marriage and how law reform can advance girls' equality and protect them from child marriage. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Parliamentarians can encourage government to develop national plans of action, with clear targets, milestones, indicators and allocated budgets to achieve SDG Target 5.3 on ending child marriage by 2030. They can also monitor and hold government ministries accountable for reporting on the progress towards achieving SDG Target 5.3.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to end child marriage and canvass for dedicated funds to be allocated to prohibit child marriages, betrothals and to encourage registration of all marriages. They can analyse budget allocations for SRH to assess whether programmes will reach child brides and girls at risk of child marriage. They can encourage various ministries (e.g. health, education, justice) to budget for programmes to end child marriage. They can work with their constituents to ensure that funding for ending child marriage reaches sub-national and local levels.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the need to eradicate child marriage. They can attend events and speak out about the harms of child marriage and frame it as an important human rights issue. They can use international or national human rights days such as the International Day of the Girl Child (11 October), to increase awareness about child marriage. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians on the causes and impact of child marriage and the importance of eradicating child marriage. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with CSOs to increase awareness, understanding and information on child marriage. They can organise field trips to investigate community actions to end child marriage. Parliamentarians can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on the prevalence of child marriage in the country, the impact it has on young girls and boys, and the challenges within the legal framework. They can empower women married as children or child brides to advocate on their own behalf. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can play an important role in ensuring that the voices of girls, women and key populations can influence all aspects of planning, including design, implementation and monitoring of national plans to end child marriage.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including marginalised and vulnerable groups such as child brides. Parliamentarians can engage with key stakeholders within communities – young people, teachers, parents, traditional leaders, religious leaders and health workers, to increase awareness of actions to end child marriage and to understand the challenges faced by those affected.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on child marriage.

References

AU Campaign to End Child Marriage
http://endchildmarriagenow.org/

Girls Not Brides
www.girlsnotbrides.org

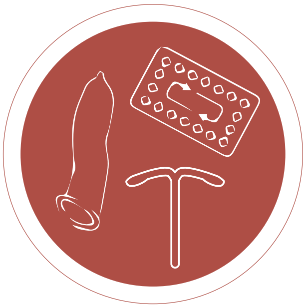
Girls Not Brides, The Role of Parliamentarians in Ending Child Marriage: A Toolkit, 2016 (revised)
http://www.girlsnotbrides.org/wp-content/uploads/2015/05/GNB_The_Role_of_Parliamentarians_2016_v9_Final.pdf

Human Rights Watch, Ending Child Marriage in Africa: Opening the Door for Girls' Education, Health and Freedom from Violence, 2015
https://www.hrw.org/news/2015/12/09/ending-child-marriage-africa

UNICEF, Ending Child Marriage, Progress and Prospects. 2013
https://www.unicef.org/media/files/Child_Marriage_Report_7_17_LR..pdf

factsheet 4

Contraception and family planning



Family planning programmes are a key component of comprehensive SRH and they provide essential services, information and commodities to women. Family planning not only benefits women, it also helps families and communities: when women are able to manage the size of their families, they can ensure that all children go to school and households have more resources for food, shelter and health care.

According to global research conducted in 2014, 225 million women who wanted to prevent or delay pregnancy were not using an effective method of contraception[51] and a 2012 study on global trends on intended and unintended pregnancies showed that about 40% of all pregnancies globally are unintended, with the highest number of these being in Africa.[52] Both married and unmarried women experience barriers to accessing contraception and to making informed decisions about family planning.

Lack of access to contraception puts women at risk of HIV and other STIs and leaves them powerless to make decisions about the most intimate aspects of their lives. The adverse health consequences of unintended pregnancy include chronic ill-health and even death, while the social costs include increased poverty, disruption of education for girls and stigma and discrimination.

In addition to preventing unwanted, unintended pregnancies, family planning services, when integrated with HIV services, provide a crucial opportunity to discuss HIV with women, helping them assess their risk of HIV, including from sexual violence, how to prevent transmission and linking them to HIV testing and counselling services. It is also a critical, and often missed opportunity, to provide targeted services for women living with HIV.

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[51] *Guttmacher Institute, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health, 2014, https://www.guttmacher.org/report/adding-it-costs-and-benefits-investing-sexual-and-reproductive-health-2014*

[52] *Sedgh, G. and others, Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends, Studies in Family Planning, 2014, http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2014.00393.x/full*

Useful definitions

Family planning is the information, means and methods that allow individuals to decide if and when to have children. This includes a wide range of contraceptives – including pills, implants, IUDs, surgical procedures that limit fertility, and barrier methods such as condoms – as well as non-invasive methods such as the calendar method and abstinence. Family planning also includes information about how to become pregnant when it is desirable, as well as treatment of infertility.

Modern contraceptive methods: the pill, injectables, IUDs, implants, female and male condoms.

Traditional contraceptive methods: abstinence[54], withdrawal.[55] These methods are not effective at preventing pregnancy and STIs. Research shows it is difficult for people to abstain indefinitely from all forms of sexual activity. In addition, women and girls do not always have control over when and how sex happens, so they may not be able to abstain from sex even should they wish to do so.

Unmet need for modern contraception: these are women who want to prevent pregnancy but who do not use contraception or use traditional contraceptive methods for various reasons, including because they do not have access, they cannot afford it or social and cultural pressures force them to become pregnant.

Vulnerable and marginalised women (who struggle to access contraception and family planning): these include women and girls living with HIV, women and girls with disabilities, adolescent girls, displaced women and girls, refugee women and girls, sex workers.

International and regional human rights obligations

The right to family planning and contraception is grounded in international and regional human rights, including the right to the highest attainable standard of health, the right to decide the number and spacing of one's children, and the rights to privacy, information and equality and non-discrimination. SADC countries have ratified international and regional human rights treaties that oblige them to protect and promote these rights.

The CEDAW states that women have the right to determine the number, spacing and timing of their children and to have access to contraception and the information needed to exercise that right. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) includes the right to decide whether to have children, and the number and spacing, as well the right of women to control their fertility and to have access to family planning education. The Protocol also includes the right to be protected against HIV and STIs.

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[53] *UNFPA, Family Planning, http://www.unfpa.org/family-planning*

[54] *Abstinence has different meanings: it may mean a complete abstention from all forms of sexual activity, but it also sometimes means an abstention from vaginal intercourse.*

[55] *Withdrawal is a method of preventing pregnancy by keeping semen away from the vagina and involves withdrawing the penis from the vagina before ejaculation.*

[56] *Centre for Reproductive Rights and UNFPA, Briefing Paper: The Right to Contraceptive Information and Services for Women and Adolescents, 2010, http://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf*

The Committee on Economic, Social and Cultural Rights and the CEDAW Committee have interpreted the right to health to include SRH and that contraceptive information and services are necessary to fulfil this right. The CSW adopted resolution 60/2 in 2016, calling on states to ensure that women can exercise their right to have control over and decide freely and responsibly on matters related to their sexuality, including their SRH, free of coercion, discrimination and violence.

In addition to their legal obligations under international human rights laws, SADC countries have also committed to achieving the SDGs, also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. Target 3.7 aims to ensure universal access to sexual and reproductive health care services, including family planning education and information, by 2030. The indicator for this target is the proportion of women of reproductive age who have their need for family planning satisfied with modern methods.

Family Planning 2020

Family Planning 2020 is a global partnership between governments, civil society, multilateral organisations, donors, the private sector and the research and development community to support women's access to contraception and their rights to decide "freely and for themselves, whether, when and how many children they want to have". The campaign plans to expand access to contraception, information and family planning services to 125 million women and girls in 69 of the world's poorest countries by 2020.

Focus countries include several SADC countries: the Democratic Republic of Congo (DRC), Lesotho, Madagascar, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe.

Human rights barriers to family planning and contraception

Harmful gender norms

Women and girls may be unable to access family planning because of family or spousal opposition, often based on religious reasons or social values. In many African countries, married women may themselves oppose contraception because they believe it is their duty to have children. Adolescent girls and young women may not be able to disclose that they are sexually active because of social norms and this may limit their ability and willingness to access contraception.

For more information on adolescent girls and young women, see factsheet two.

Lack of information and education on contraception and family planning

Many women struggle to access information about modern contraception and do not understand how contraception works or which method would work best for them. The lack of information does not only impede access because women do not demand access, but it also leads to misconceptions about the side effects and health risks associated with contraception which may deter women from asking for and using contraception. For example, some women believe that hormonal contraception may make them infertile or cause cancer.

In Africa, studies show that many married women do not use contraception if they have not resumed menstruation post-pregnancy, they are still breast-feeding or both because they do not believe they can get pregnant.[57]

Women living with HIV and family planning

Family planning services rarely provide targeted services and information to women living with HIV, who have both the same and different family planning needs as other women. They have a higher risk of contracting STIs and need specific information about their options for contraception, including access to male and female condoms.

Women living with HIV have the right to become pregnant and have children. They should be able to decide whether they wish to have children and to plan their pregnancies, but they frequently cannot access accurate information that allows them to make informed decisions about pregnancy and children in the context of their HIV status. Some may be pressurised by health care workers, families and sexual partners to be sterilised and women living with HIV in some SADC countries have reported being sterilised without their informed consent.

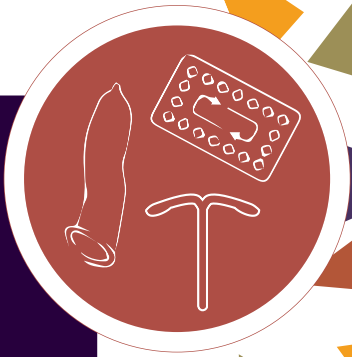
Consequences of the lack of access to contraception and information

Health consequences of unintended pregnancy

Women who do not have access to contraception are unable to prevent or delay their pregnancies and many, especially vulnerable and marginalised women and adolescent girls, experience negative health consequences as a result. Providing access to all women in developing countries who have an unmet need for contraception would prevent: 54 million unintended pregnancies, 16 million unsafe abortions and 7 million miscarriages, 79 000 maternal deaths and 1.1 million infant deaths.[58]

[57] *Guttmacher Institute, Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method, June 2016, https://www.guttmacher.org/report/unmet-need-for-contraception-in-developing-countries*

[58] *WHO, Ensuring human rights in the provision of contraceptive information and services, 2014 http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf?ua=1*



Economic benefits of ensuring access to contraception for all women

Unwanted and unintended pregnancy is a significant cause of poverty for women in developing countries and there are clear economic benefits to investing in family planning. For every additional dollar that is invested in contraception, the cost of pregnancy-related care will be reduced by $2.22. In terms of socio-economic benefits, achieving universal access to quality sexual and reproductive health services is estimated to yield returns of $120 for every dollar invested.

Providing contraception and contraceptive information and education can save women's lives and allow them to live more productive lives and reducing gender inequality.

Lack of sexual autonomy

Lack of access to contraception undermines the ability of women to control their fertility and health, undermining their ability to enjoy a satisfying sex life.

What can parliamentarians do to advance access to family planning and contraception?

Undertake advocacy research: Parliamentarians can initiate research into the barriers to family planning, including the lack of education about contraception both inside and outside hospital and clinic facilities. This research should pay specific attention to the family planning needs of women living with HIV, female members of key populations and young women, as well as the specific barriers they face in accessing services and information. It is important for parliamentarians to understand the reasons why women in their countries are not accessing contraception as reasons will differ between countries. Further, by understanding the dynamics in their own countries, parliamentarians could encourage evidence based policies and programming. Parliamentarians can investigate the availability of family planning in public health facilities and whether health care workers have been trained to advise and administer contraception, including to women living with HIV, female members of key populations and young women. They can also investigate the availability of CSE for adolescents and young people that includes information and education about family planning and contraception. Parliamentarians can also initiate research into special programmes that promote access to contraception and information to marginalised and vulnerable women.

Enact and strengthen protective laws: Parliamentarians can draft and enact laws promoting access to family planning. They can ensure that laws:

- Promote equal, non-discriminatory access to family planning and contraception, ensure that women are able to make informed decisions about contraception and give their informed consent before using any form of contraception;
- Promote access to family planning and contraception for young women, women living with HIV, female members of key populations and other marginalised and vulnerable women;
- Prohibit any form of coercion in access to contraception, including sterilisation;
- Do not criminalise methods of preventing pregnancy, including abortion;
- Do not require spousal or parental consent to access contraception and contraceptive information;
- Respect the right to medical confidentiality for women and girls; and
- Promote access to CSE for adolescents and young men and women, including information about contraception.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance access to family planning and contraception. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enact protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance. Parliamentarians can encourage government to develop national plans of action, with clear targets, milestones, indicators and allocated budgets, to achieve SDG Target 3.7 on ensuring universal access to sexual and reproductive health care services. They can monitor and hold government ministries accountable for reporting on their progress towards achieving SDG Target 3.7.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated to advancing universal access to SRHR, including family planning and contraception and ensure that budgeted programmes for family planning and contraceptive methods are tailored to the needs of the community, taking into account conservative traditions and practices of certain social groups and communities and indicating clearly the scientific evidence available on reproduction and ways to control it safely. They can analyse budget allocations for SRH to assess that programmes will reach the women and girls who most need them. They can encourage various ministries (e.g. health, education, justice) to budget for relevant programmes and that human rights are fully integrated into programmes on contraception and appropriately costed to ensure implementation.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the importance of access to contraception and family planning for all women who wish to enforce their human rights to decide on the number and spacing of their children. They can play a particularly important role in destigmatising women living with HIV who want to get pregnant by framing access to family planning as a human right for everyone. By speaking out, parliamentarians can encourage a human rights-based approach to family planning and more social acceptance of contraception and support for women to access and use them. They can use international or national human rights days, including World Contraception Day (26 September) to increase awareness about the negative consequences of unintended pregnancy and the importance of universal access to contraception. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness and share lessons learned amongst fellow parliamentarians at regional and global levels.

Engage with civil society: Parliamentarians can engage with CSOs, including women's groups, health care workers and other groups working on women's reproductive health to increase awareness, understanding and information on SRHR including access to family planning and contraception. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on the barrier to access contraception, including for vulnerable groups, the harmful consequences of unintended pregnancies and challenges within the legal framework that prevent women, or particular groups of women from accessing contraception. Parliamentarians can play an important role in ensuring that the voices of women and girls, including those living with HIV, are included in discussions about their lives and that they can influence all aspects of contraceptive planning, including design, implementation and monitoring.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including women and girls. Parliamentarians can engage with key stakeholders within communities such as women, HIV support groups, health care workers, parents, traditional leaders and religious leaders, to increase awareness about human rights and family planning. In particular, parliamentarians can ensure that they include the voices on girls and young women at the centre of these conversations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on SRHR, including access to contraception. They can encourage the media to write stories that sensitively convey the consequences of unintended pregnancy, that portray the contraceptive needs of women and girls, including those living with HIV and key populations, accurately and without judgment and that provide relevant and reliable information about the public health benefits of contraception. They can encourage journalists to seek out women living with HIV and report their stories.

References

Centre for Reproductive Rights and UNFPA, Briefing Paper: The Right to Contraceptive Information and Services for Women and Adolescents, 2010
http://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf

Guttmacher Institute, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health, 2014
https://www.guttmacher.org/report/adding-it-costs-and-benefits-investing-sexual-and-reproductive-health-2014

United Nations Population Fund (UNFPA), Family Planning
http://www.unfpa.org/family-planning

United Nations, Department of Economic and Social Affairs, Trends in Contraceptive Use Worldwide 2015,
http://www.un.org/en/development/desa/population/publications/pdf/family trendsContraceptiveUse2015Report.pdf

WHO, Ensuring human rights in the provision of contraceptive information and services, 2014
http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf?ua=1

Safe Abortion

Access to safe abortion is a key component of SRH and countries have clear human rights obligations to ensure that women can access safe abortions in accordance with their rights to health and non-discrimination and equality.

Very few countries in Africa have laws that promote access to safe and legal abortion; a 2015 study estimated that 93% of African women live in countries with restrictive abortion laws that either prohibit abortion completely or only allow it in very limited circumstances.[61] A 2012 Guttmacher study showed that abortions are increasingly concentrated in developing countries and correlate with poor access to contraception.[62] Improving access to contraception would therefore significantly reduce the number of unintended pregnancies and therefore abortions.

For more information about contraception and family planning, see factsheet five.

Unsafe abortion can have catastrophic health consequences for women and girls: WHO estimates that approximately 47 000 women die each year as a result of unsafe abortions, largely in countries with highly restrictive laws. Another eight million women suffer serious and sometimes permanent injury as a result of complications from unsafe abortion.

Women living with HIV have the same right to choose to terminate a pregnancy, but they need additional information and services to make informed decisions, including information about the risks to their health of continuing a pregnancy and the availability of ART to prevent mother to child transmission.

Decriminalising abortion and removing legal barriers to abortion and post-abortion care is not only a critical part of realising SRHR, but a public health necessity.

The CEDAW does not explicitly mention abortion, but the CEDAW Committee has consistently criticised restrictive abortion laws on the basis that these laws, particularly those that criminalise abortion in all circumstances, violate women's

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[61] *Guttmacher Institute, Facts on Abortion in Africa, 2015, https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB_AWW-Africa.pdf*

[62] *Guttmacher Institute, Access to Safe Abortion in the Developing World: Saving Lives While Advancing Rights, 2012, https://www.guttmacher.org/gpr/2012/10/access-safe-abortion-developing-world-saving-lives-while-advancing-rights*

right to health. The Committee has encouraged states to review punitive abortion laws. The UN Human Rights Committee has made similar criticisms.

In 2011, the Special Rapporteur on the Right to Health issued a report that condemned both forced abortions and forced pregnancies as violations of the right to health. The ground-breaking report states the "criminal prohibition of abortion is a very clear expression of state interference with a woman's sexual and reproductive health because it restricts a woman's control over her body".[63] The report encourages States to take measures to ensure that safe and legal abortion services are available, accessible and of good quality.

Criminalisation and other human rights barriers to safe abortion

Legal status of safe abortion in SADC countries

Countries	No restrictions	To save the life of the woman	On the grounds of sexual violence	Foetal impairment	To protect the physical and mental health of the woman
Angola		X			
Botswana		X	X	X	X
DRC		X			
Lesotho		X			
Madagascar		X			
Malawi		X			
Mauritius		X	X	X	X
Mozambique	X (until 12 weeks)				
Namibia		X	X	X	X
Seychelles		X	X	X	X
South Africa	X				
Swaziland		X			
Tanzania		X			X
Zambia		X		X	X
Zimbabwe		X	X	X	

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[63] *UN General Assembly, Right of Everyone to the enjoyment of the highest attainable standard of physical and mental health, 3 August 2011, http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254*

Continental campaign to decriminalise safe abortion

In 2016, the African Commission on Human and Peoples' Rights and the Special Rapporteur of the Rights of Women in Africa launched a campaign to decriminalise abortion in Africa. The campaign aims to reduce the number of deaths related to unsafe abortions and to prevent women and girls from being criminally charged for having abortions.

At the launch of the campaign, the Special Rapporteur called on all states to honour their commitments in terms of the Maputo Protocol and the African Charter on Human and People's Rights. She emphasised that "criminalising abortion violates many basic human rights, including the right to: life, liberty, security, health, and freedom from torture. Criminal abortion laws discriminate on the basis of sex - they penalise a health service only women need."[64]

The majority of women and girls in SADC countries do not have access to safe and legal abortions and the only SADC country to fully decriminalise abortion is South Africa. Evidence shows that the criminalisation does not reduce demand, but rather forces women and girls to seek out illegal and unsafe abortions. Criminalisation also deters women who have had illegal abortions from seeking post-abortion care, including when they experience complications, because they fear arrest and prosecution.

Lack of access to safe abortion-related information

Even where abortion is available under limited circumstances, women and girls struggle to access information about where and how to access safe and legal abortions, leading to delays and often a failure to access abortion timeously. Vulnerable women such as sex workers, women with disabilities and women living with HIV may experience additional barriers to accessing reliable and accurate information about the availability of abortion. For example, women living with HIV may lack information about the impact of pregnancy on their health, while women with disabilities may not be able to access accessible information to allows them to make informed decisions about their reproductive health.

Abortion-related stigma

The criminalisation of abortion and social and religious resistance to abortion contributes to high levels of stigma and fear, which have a chilling effect on women's willingness to ask for information about abortion, access legal abortion and seek post abortion care, including where abortion is legal.

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[64] *International Campaign for Women's Right to Safe Abortion, Statement by the Special Rapporteur on the Rights of Women in Africa, 2016, http://www.safeabortionwomensright.org/africa-statement-by-the-special-rapporteur-on-the-rights-of-women-in-africa/*

HIV and safe abortion

Women living with HIV who get pregnant often face judgemental and stigmatising attitudes from health care workers and cannot access information about their full range of options, including abortion. Information about abortion should form part of a comprehensive package of reproductive health care and information offered to pregnant women with HIV.

Some women living with HIV may feel pressurised to terminate their pregnancies by health care workers, partners and family, and may resort to unsafe abortions in countries where abortion is criminalised. Conversely, women living with HIV who want to end their pregnancies, are frequently unable to do so because abortion is criminalised or because they cannot access information about their reproductive options.

Consequences of lack of access to safe abortion and post-abortion care

Unsafe abortion is one of the leading causes of maternal mortality and injury. The improvements in maternal health care have led to a global reduction in the number of women and girls who die in childbirth, but the proportion of deaths attributable to unsafe abortion remains steady at 13%. In 2014, in Africa, 9% of maternal deaths (16 000) were caused by unsafe abortion.[65]

South Africa and safe abortion

The South African Parliament adopted the Choice on Termination of Pregnancy Act in 1996. The ruling African National Congress (ANC) ruled that all its parliamentarians had to vote in favour of the Act, even though some had requested to be allowed to vote in accordance with their personal beliefs, and the act was passed by 209 votes to 87. The Act came into force in 1997.

Although there are significant challenges with the implementation of the Act, it does demonstrate how decriminalising abortion has significant benefits for women's health: abortion-related deaths have decreased by up to 90% in some places in the years following the enactment of the Choice Act.

The preventable deaths caused by unsafe abortions levy enormous financial, social and emotional costs on families, communities and society.

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[65] *Guttmacher Institute, Facts on Abortion in Africa, 2015, https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB_AWW-Africa.pdf*

Economic costs of unsafe abortion

An Ethiopian study presents one of the first comprehensive looks at the true cost to the national health system of providing post abortion care. It found that the direct cost of treating post abortion complications in 2008 was $7.6 million, or $36 per woman treated. This in a country where the average person lives on less than one dollar a day.

Ethiopia expanded access to legal abortion in 2005. Previously, abortion was only legal to save the life of the woman or to protect her physical health. Following a change in the law, women can now terminate pregnancies that are the result of sexual violence and incest and in cases of foetal impairment. Women can also terminate pregnancies if they cannot raise the child as a result of their age (i.e. if they are minors) or because of mental or physical disability.

Despite the partial decriminalisation of abortion, many women continue to struggle to get access to safe and legal abortions.[67]

What can parliamentarians do to advance access to family planning and contraception?

The right to safe abortion is now recognised as an integral part of reproductive rights and various provisions in regional and international human right instruments have been interpreted to include access to safe abortion. It is most strategic to advance the right to safe abortion progressively bearing in mind country-specific religious and moral beliefs and with continuous dialogue and consultation of religious and community leaders. The role of parliamentarians in this respect is crucial as both their representative and leadership roles are at play in standard-setting and convincing communities to adopt a change of mind-sets, where necessary, in advancing the access to safe abortion agenda.

They can also help to ensure that abortion is medically supervised and carried out by qualified personnel in hospital settings that provide emergency obstetric care.

Undertake advocacy research: Parliamentarians can initiate research into the negative consequences of unsafe abortions and commission research into economic

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[67] *Guttmacher Institute, Facts on Unintended Pregnancy and Abortion in Ethiopia, 2010https://www.guttmacher.org/sites/default/files/factsheet/fb-up-ethiopia.pdf*

costs of providing post-abortion care for unsafe and/or illegal abortions. Parliamentarians can investigate the barriers to access to legal abortion (even where it is restricted to limited circumstances), including lack of information about availability, inadequate training of health care workers, and costs. Parliamentarians can investigate unintended and unwanted pregnancy amongst marginalised and vulnerable women, including women living with HIV, and their need for abortion and post-abortion care.

Enact and strengthen protective laws: Parliamentarians can draft and enact laws promoting access to comprehensive SRHR, including abortion. They can ensure that laws:

- Decriminalise access to abortion, abortion related information and post-abortion care;
- Promote equal, non-discriminatory access to abortion where it is legal, even in limited circumstances;
- Provide clear guidance when abortion is available on limited grounds so that health care workers and women know when they are able to provide or access abortion;
- Promote access to unbiased and comprehensive pregnancy counselling;
- Promote equal, non-discriminatory access to contraception and contraceptive information and ensure that women are able to make informed decisions about contraception and give their informed consent before using any form of contraception;
- Promote access to contraception for marginalised and vulnerable women, including women living with HIV, sex workers and women who use drugs;
- Prohibit any form of coercion in access to contraception, including sterilisation;
- Do not criminalise methods of preventing pregnancy;
- Do not require spousal or parental consent to access contraception and contraceptive information or abortion, where it is available; and
- Promote respect for the right to medical confidentiality for women and girls.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess whether laws and policies are consistent with international and regional human rights commitments. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to decriminalise abortion and provide access to comprehensive sexual and reproductive health care. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress and achievements to achieve the SDGs.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to advance universal access to SRHR, including access to abortion, where it is legal, and post-abortion care. They can analyse budget allocations for SRH to assess that programmes will reach vulnerable and marginalised women. They can encourage various ministries (e.g. health, education and justice) to budget for relevant programmes and that human rights are fully integrated into abortion services and appropriately costed to ensure implementation.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on abortion as a key part of the right to SRHR. By speaking out, parliamentarians can help to de-stigmatise abortion and increase acceptability of abortion as a component of comprehensive sexual and reproductive health care. They can attend events, deliver speeches and work with the media to frame access conversations about abortion as a human rights issues. They can use international or national human rights days, including the Global Day of Action for Access to Safe and Legal Abortion (28 September) to increase awareness about the harms of unsafe abortions and the importance of universal access to contraception and they can promote the Continental Campaign to decriminalise abortion. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with CSOs, health care workers and other groups working on women's reproductive health to increase awareness, understanding and information about abortion and the harms of unsafe abortion. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings about the challenges women and girls face in accessing safe abortions and the barriers to contraception. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can play an important role in ensuring that the voices of women, including women living with HIV, and the perspectives of families and communities affected by lack of access to abortion, are included in debates on the matter.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate. Parliamentarians can engage with key stakeholders within communities – women, health care workers, parents, traditional leaders and religious leaders, to increase awareness to about SRHR, including abortion. In particular, parliamentarians can ensure that they include the voices of girls and young women at the centre of these conversations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on abortion. They can encourage the media to write stories that sensitively convey the consequences of unintended pregnancy, that portray the choice to have an abortion accurately and without judgment and that provide relevant and reliable information about access to abortion and post abortion care. They can frame abortion as human rights issue and a public health imperative.

References

Centre for Reproductive Rights, Bringing Rights to Bear: Briefing Paper on Abortion and Human Rights, 2008
https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_abortion_hr_revised_3.09_WEB.PDF

Guttmacher Institute, Facts on Abortion in Africa, 2015
https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB_AWW-Africa.pdf

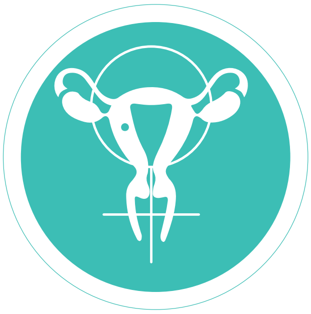
International Community of Women Living with HIV/AIDS, Addressing the Needs of HIV-Positive Women for Safe Abortion Care, 2008
https://www.icw.org/files/ICW%20abortion%20briefing%20paper%206-08.pdf

Office of the High Commissioner on Human Rights (OHCHR), Information series on Sexual and Reproductive Health and Rights, Abortion
http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf

factsheet 6

Cervical cancer screening and prevention

Cervical cancer is the most common cancer in women in sub-Saharan Africa, partly due to the high levels of HIV amongst women, and the leading cause of cancer deaths in Southern Africa amongst women. Despite this, access to prevention, screening and treatment programmes are inadequate in the region, leading to high levels of preventable death and unnecessary illness and suffering. In 2012, just over half a million new cases of cervical cancer were diagnosed and 266 000 women died of the disease, with 90% of them living in low- and middle-income countries.[68]



A 2012 report on cervical cancer and human rights in Southern Africa describes cervical cancer as “a disease of inequality and poverty.”[69] Poor women, women living in rural areas, women and girls living with HIV and other marginalised women are at heightened risk of cervical cancer and are less likely to have access to comprehensive prevention, screening and treatment services.

Cervical cancer is a largely preventable and treatable form of cancer, especially if diagnosed early. A key part of cervical cancer prevention is the Human Papilloma Virus (HPV) vaccination, administered to adolescent girls. Screening for cervical cancer is important for all women, but it is particularly important for women and girls living with HIV. Women and girls living with HIV are four to five times more likely than HIV-negative women and girls to get cervical cancer, which has been recognised as an AIDS defining illness. Unfortunately, countries with high levels of HIV are often those with insufficient cervical cancer programming.

Access to cervical cancer prevention, screening and treatment are part of a comprehensive package of sexual and reproductive health care and the failure to provide them undermines the SRHR of women, including those living HIV.

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[68] *UNAIDS, HPV, HIV and cervical cancer: Leveraging synergies to save women’s lives, 2016, http://www.unaids.org/sites/default/files/media_asset/JC2851_HPV-HIV-cervicalcancer_en.pdf*

[69] *Southern African Litigation Centre, Tackling Cervical Cancer: Improving Access to Cervical Cancer Services for Women in Southern Africa, 2012, http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/11/CERVICAL-CANCER-Report1.pdf*

Useful definitions

Cervical cancer: this is a form of cancer that begins in the cervix and it is largely caused by the Human Papilloma (HP) virus. It is a slow-growing cancer and in some cases, can take up to 20 years to develop.

Human Papillomavirus (HPV): causes invasive cancer, including cervical cancer and is transmitted through sexual contact. Penetration is not required for transmission of HPV.

HPV vaccine: the vaccine is a form of primary prevention for cervical cancer. The first HPV vaccine was approved in 2006.

Hysterectomy: a surgical procedure (operation) to remove all or parts of the uterus.

Palliative care: WHO defines palliative care as “[A]n approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

Pap smears: this is a form of cancer screening by examining cells under a microscope. Cells are scraped from the cervix and examined for cancer or pre-cancerous changes.

International and regional human rights obligations

SADC countries have international and regional human rights obligation to provide effective prevention and treatment services for cervical cancer. These include the right to life, the highest attainable standard of health, to equality and non- discrimination and access to information. The Southern African Litigation Centre concluded that these “legal obligations … require countries to issue and implement national policies on comprehensive cervical cancer management; ensure women have full information on cervical cancer; make available and provide access to prevention, screening and treatment services for cervical cancer and make provision for palliative care for women with advanced cervical cancer.”[70]

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[70] *Southern African Litigation Centre, Tackling Cervical Cancer: Improving Access to Cervical Cancer Services for Women in Southern Africa, 2012, http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/11/CERVICAL-CANCER-Report1.pdf*

Joint UN programme on cervical cancer prevention and control

The Programme was launched in May 2016 and will support governments in developing countries to implement functioning and sustainable high-quality national comprehensive cervical cancer control programmes that allow women to access services equitably.

This is in line with the UNAIDS 2016–2021 Strategy, which emphasises that prevention, treatment, care and support services should be integrated with services that address coinfections and comorbidities, and with sexual and reproductive health services.

Key components of a comprehensive approach to cervical cancer

Prevention

Prevention is an essential part of a cervical cancer programme and there are both primary and secondary prevention measures:

- Primary prevention revolves around preventing HPV infection. The HPV vaccine has been proven to significantly reduce the burden of cervical cancer and the WHO recommends that the vaccine be given to adolescent girls between the ages of 9 and 13 because it is most effective if administered before girls become sexually active; and
- Secondary prevention focusses on screening and detection of cervical cancer and the treatment of pre-cancerous lesions. This is done through a pap smear and the WHO recommends that in resource poor settings, pap smears are given to women at the age of 30, and then every three years.

Access to cheaper HPV vaccines

Gavi, the Vaccine Alliance, is a public–private partnership that has brought about significant reductions in the cost of HPV vaccines, which are now available in developing countries for about US$ 4.50 per dose (compared to US$100 in developed countries). Gavi have planned to support more than 20 countries[71] to vaccinate approximately one million girls with HPV vaccines through demonstration projects by 2015. By 2020, more than 30 million girls are expected to have been vaccinated in more than 40 countries through Gavi support.[72]

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[71] *SADC countries include Madagascar, Malawi, Mozambique, Tanzania and Zimbabwe*

[72] *UNAIDS, HPV, HIV and cervical cancer: Leveraging synergies to save women's lives, 2016, http://www.unaids.org/sites/default/files/media_asset/JC2851_HPV-HIV-cervicalcancer_en.pdf*

Diagnosis

If abnormal results are obtained after a pap smear, additional tests must be done to determine the extent of the pre-cancer or cancer.

Treatment

There are various options available for the treatment of pre-cancerous lesions and cancer.

- **Pre-cancer:** there are two treatments for pre-cancerous lesions, which both involve the removal of the abnormal tissue. One involves the freezing off of the area through a process called cryotherapy or the removal of the tissue using loop electrosurgical excision procedure (LEEP). Cryotherapy is appropriate for low resource settings because it does not require anaesthetic and it can be performed by primary health care workers if they have been adequately trained and are appropriately supervised; and

- **Cancer:** the earlier that cervical cancer is diagnosed, the better the chance of survival. There are various treatment options, depending on the stage of the cancer. These include hysterectomy, chemotherapy and radiation.

Palliative care

Palliative care provides pain relief and addresses the end of life needs of patients and their families.

Women living with HIV and cervical cancer

Women living with HIV are more susceptible to cervical cancer and are more likely to be infected with the HP virus.[73] Women with HIV are more likely to develop pre-cancerous lesions that, if not treated, will quickly progress to cervical cancer. The WHO recommends screening and providing adequate treatment to all women living with HIV as soon as they know their status and if they are or have been sexually active.

Human rights barriers to comprehensive cervical cancer prevention, screening and treatment

The 2012 Southern Africa Litigation Centre report on cervical cancer in Southern Africa concluded that very few SADC countries are effectively addressing cervical cancer, with few having comprehensive cervical cancer policies in place. In order to prevent unnecessary deaths, governments must ensure that women are able to access a comprehensive cervical cancer programme that includes primary prevention, screening, treatment, palliative care and makes adequate provision for the special needs of women living with HIV or those at higher risk of HIV. The HPV vaccine is not widely available for free in many SADC countries and other barriers to prevention, screening and treatment include a lack of trained health care workers and inadequate laboratory facilities.

In addition to the structural barriers, there are human rights issues that prevent women and girls from accessing care where it is available, including the following:

Lack of information about cervical cancer and misperceptions about the HPV vaccine

Research shows that there are low levels of knowledge about cervical cancer in Southern Africa.[74] The lack of information amongst women and girls, parents and health care workers, creates obstacles to access services, even if they do exist, and reinforces negative attitudes on the part of health care workers about sexual and reproductive health care. Girls and young women are especially vulnerable to stigma and discrimination when they seek sexual and reproductive health care, including information on cervical cancer. Lack of information particularly undermines prevention efforts which depend on women and communities being aware of, and understanding their risks and what prevention and screening services are available.

Young women and girls also face particular challenges in accessing information about their risk of cervical cancer and HPV infection. There are many misconceptions about the HPV vaccine, including whether it is safe to administer and whether it promotes promiscuity. There are insufficient programmes that target parents and care givers about why it is important to vaccinate girls and the health benefits of the vaccine. Health care workers are often not trained to provide information and care to young women and girls and they lack the necessary skills to support this group of vulnerable women. In addition, age of consent laws may prevent girls from accessing services related to cervical cancer without the consent of their parents or guardians.

For more information on adolescent girls and young women, please see factsheet two.

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[73] *UNAIDS, HPV, HIV and cervical cancer: Leveraging synergies to save women's lives, 2016, http://www.unaids.org/sites/default/files/media_asset/JC2851_HPV-HIV-cervicalcancer_en.pdf*

[74] *Southern African Litigation Centre, Tackling Cervical Cancer: Improving Access to Cervical Cancer Services for Women in Southern Africa, 2012, http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/11/CERVICAL-CANCER-Report1.pdf*

Stigma associated with sexual and reproductive health care, including cervical screening

Women in Southern Africa often face stigma when they seek out sexual and reproductive health care. Cervical screening and its association with STIs is often seen as an indication of sexual promiscuity, deterring women from asking for these services. Women may fear that when it is disclosed that they sought out cervical cancer screening, they will be abandoned by their partners and ostracised by their community.

Gender inequality

Women do not always have the power to access sexual and reproductive health care without the permission of their spouses or sexual partners. These concerns may be especially acute for women in rural areas and who live under customary laws.

What can parliamentarians do to advance prevention, screening and treatment for cervical cancer?

Parliamentarians can play a critical role in ensuring that the myths and misinformation about cervical cancer, arising in part from custom and tradition, are dispelled and women and girls, including those living with HIV, receive the right information at the right time in order to make informed decisions about their health.

Undertake advocacy research: Parliamentarians can initiate research into the human rights barriers to prevention, screening and treatment programmes for cervical cancer. Parliamentarians can investigate the barriers faced by women living with HIV and vulnerable women and ensure that their needs are adequately addressed. They can commission research on the potential to scale up access to the HPV vaccine and cervical cancer screening and treatment.

Enact and strengthen laws: Parliamentarians can draft and enact laws promoting access to comprehensive prevention, screening and treatment for cervical cancer. They can ensure that laws:

- Promote equal, non-discriminatory access to cervical cancer programmes and ensure that women are able to make informed decisions about their health, including access to the HPV vaccine;
- Promote access to cervical cancer programmes for women living with HIV and marginalised or vulnerable women;
- Do not require spousal or parental consent to access information about cervical cancer;
- Do not require spousal or parental consent to access the HPV vaccine;

- Respect the right to medical confidentiality for women and girls; and
- Promote CSE for adolescents and young men and women, including information about the risk of cervical cancer.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments and do not hamper access to cervical cancer services. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance access to cervical cancer programmes. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enact protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance. Parliamentarians can encourage governments to develop national cervical cancer plans to address the need to improve services and work with the medical profession to ensure they are evidence based. They can monitor and hold government ministries accountable for reporting on their progress towards implementing these plans.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to advance universal access to SRHR, including cervical cancer programmes. The budget should include provision for medical equipment and technology required to track and diagnose cervical cancer at its early stages, and should monitor that equipment reaches hospitals or health care centres spread across the country. They can analyse budget allocations for SRH to assess that programmes include cervical cancer programming and that programmes will reach the most vulnerable women, including women living with HIV. They can encourage various ministries (e.g. health, education, justice) to budget for relevant programmes and that human rights are fully integrated into programmes on cervical cancer and are appropriately costed to ensure implementation.

Be an opinion leader and influencer: Parliamentarians can help raise awareness about cervical cancer, the HP virus and the links between HIV and HPV. They can become opinion leaders on the importance of access to the HPV vaccine and help to de-stigmatise adolescent sexuality so that girls can access to HP vaccination. By speaking out, parliamentarians can encourage a human rights-based approach to cervical cancer and more social acceptance of cervical cancer prevention and screening. They can actively support CSE, including for the girls that are due to receive the vaccine. They can attend events and deliver speeches to frame cervical cancer as a human rights issues. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians. They can share lessons learned with other parliamentarians at regional and global level, including from outreach to communities on HIV.

Engage with civil society: Parliamentarians can engage with CSOs including women's groups, primary health care workers, university medical schools, private practitioners and other groups working on women's reproductive health to increase awareness, understanding and information on cervical cancer. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on the barriers to cervical cancer programmes, including for vulnerable women and work with these groups to promote the right to health for women with cervical cancer. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can play an important role in ensuring that the voices of women are included in discussions about their lives.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including women living with HIV and women and girls at higher risk of cervical cancer. Parliamentarians can engage with key stakeholders within communities – women, health care workers, parents, traditional leaders and religious leaders, to increase awareness to about cervical cancer. In particular, parliamentarians can ensure that they include the voices of women, including women living with HIV, girls and young women, at the centre of these conversations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage more reporting on cervical cancer. They can encourage the media to write stories that sensitively convey information about cervical cancer, the increased risk for women living with HIV, the need for adolescent girls to access the HPV vaccine and provide accurate information about screening and treatment for cervical cancer.

References

UNAIDS, HPV, HIV and cervical cancer: Leveraging synergies to save women's lives, 2016
http://www.unaids.org/sites/default/files/media_asset/JC2851_HPV-HIV-cervicalcancer_en.pdf

Southern African Litigation Centre, Tackling Cervical Cancer: Improving Access to Cervical Cancer Services for Women in Southern Africa, 2012
http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/11/CERVICAL-CANCER-Report1.pdf

factsheet 7

Key populations

Although most countries in SADC have generalised HIV epidemics, certain groups of people such as sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people, have been identified as key populations whose needs and vulnerabilities are insufficiently addressed.[75] Although HIV risks are much higher amongst these groups than in the general population, access to services is often far lower due to inadequate political will, widespread stigma, discrimination and other human rights abuses, under-resourced community capacity, and punitive laws that deter service uptake.[76]

UNAIDS states that ending the AIDS epidemic in Southern and East Africa will require the HIV transmission among the four populations to be dramatically lowered. In particular, lowering rates of HIV among female sex workers and their clients will have the greatest impact on the regional epidemic as they have the highest HIV prevalence of any population.[77]

This factsheet focusses on gay men and other men who have sex with men, sex workers and transgender women because of their specific SRHR needs.

Key populations by the numbers[78]

- HIV prevalence among men who have sex with men ranges from 3.8% to 36% in Southern and East Africa, and transmission within this population accounts for 6% of new HIV infections.
- In seven countries (Botswana, Lesotho, Malawi, Namibia, Rwanda, South Africa and Zimbabwe), more than 50% of sex workers are living with HIV.
- Little information is available regarding the HIV burden among transgender people in the region, although globally transgender women are 49 times more likely to be living with HIV than the general population.

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[75] *UNAIDS, Towards Ending AIDS in Eastern and Southern African Region: Leaving no one behind, a focus on sex workers, men who have sex with men, people who inject drugs and transgender people, 2017, http://www.ehpsa.org/all-documents/general/revhivprev/revitalising-hiv-prevention/2017/2-regional-synthesis-four-populations-left-behind-for-the-esa-region/brochure/336-brouchure-from-the-regional-syntheis/file*

[76] *Ibid.*

[77] *Ibid.*

[78] *Ibid.*

Useful definitions

Gender identity: refers to a person's persistent and consistent sense of being male, female or androgynous (in between). An internalised representation of gender roles and an awareness from infancy which is reinforced during adolescence.

Homophobia: an irrational fear of homosexual feelings, thoughts, behaviours or people and an undervaluing of homosexual identities, resulting in prejudice, discrimination and bias against homosexual individuals.

Key populations in the context of HIV: groups that experience a high epidemiological impact combined with reduced access to services and/or being criminalised or otherwise marginalised. Key populations in the HIV response include gay, bisexual and other men who have sex with men; people who inject drugs, and/or who are sex workers; as well as all transgender people who are socially marginalised, often criminalised and face a range of human rights abuses that increase their vulnerability to HIV.

Sex work: sex workers include female, male and transgender adults and young people (aged 18 – 24) who receive money or goods in exchange for sexual services, either regularly or occasionally.

Sexual orientation: the attraction between two people on various levels (emotionally, physically, intellectually, spiritually and sexually).

International and regional human rights obligations

Key populations, like all other people, are entitled to the full protection of all their rights under international and regional human rights laws, including their right to the highest attainable standard of health, privacy, liberty and security, freedom of expression and assembly, freedom from violence and arbitrary arrest and equality and non-discrimination.

The Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity[79]

The Principles were adopted in 2006 to provide detailed guidance about how international human rights law can be applied to sexual orientation and gender identity issues. The Principles are grounded in the recognition of non-discrimination and state all people, including Lesbians, Gays, Bi-sexual,Transgender and Intersex (LGBTI) people, should be recognised as being born free and equal in dignity and rights. According to the Principles, states are obliged to ensure equal access to human rights to LGBT people.

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[79] *The Yogyakarta Principles are available at: http://www.yogyakartaprinciples.org/principles-en/*

Equality and non-discrimination are key provisions in international and regional human rights treaties, including the African Charter on Human and Peoples' Rights, the International Covenant on Civil and Political Rights (ICCPR), the CEDAW, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) and the CRC. The African Commission on Human and Peoples' Rights, in interpreting member states' obligations, ruled that discrimination on the basis of sexual orientation is a violation of the Charter. The UN Committee on Economic, Social and Cultural Rights has also clarified that discrimination on the grounds of sexual orientation and gender identity is prohibited. The same committee has also directed states to take all steps necessary for the prevention, treatment and control of the HIV epidemic and this includes ensuring access to condoms and other HIV prevention services and commodities and information.

African Commission on Human and Peoples' Rights resolution on the protection against violence and other human rights violations against persons on the basis of their real or imputed sexual orientation or gender identity, 2014

This resolution, considered to be a landmark in the struggle for equality and justice for LGBTI people in Africa, was adopted by the Commission in 2014 and condemns violence on the basis of sexual orientation and gender identity in all forms. The resolution obliges states to enact and enforce laws prohibiting and punishing violence on the basis of sexual orientation and gender identity, or perceived Sexual Orientation and Gender Identity (SOGI). States are also obliged to investigate violence, identify and prosecute perpetrators and ensure that the justice system is responsive to the needs of LGBTI victims.

In addition to their legal obligations under international human rights laws, SADC countries have also committed to achieve the SDGs, also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. Goal 3 focusses and good health and wellbeing and sets several important targets for 2030, including ensuring universal access to sexual and reproductive health care services, ending the HIV epidemic and strengthening prevention and treatment for substance abuse. Target 10 focusses on reducing inequalities within and amongst countries and by 2030, countries should empower and promote social, economic and political inclusion for everyone and eliminate discriminatory laws, policies and practices.

The 2016 Political Declaration for Ending AIDS includes a pledge to eliminate stigma and discrimination and to create enabling legal, social and policy frameworks to support the elimination of stigma and discrimination and end HIV-related information.

In October 2017, SADC developed a regional strategy to advance prevention, treatment, care and support and SRHR for key populations. The regional strategy will guide the adoption and institutionalisation of a “standard, comprehensive package that addresses the unique challenges of providing equitable and effective HIV and SRH rights and services to key populations.”

SADC regional strategy for HIV and AIDS prevention, treatment and care and sexual and reproductive health and rights amongst key populations

SADC member states will use the strategy to:

- Design and implement effective SRH and HIV prevention, treatment and care programmes for key populations which meet their needs;
- Design a package of services for key populations in line with the standard package of services as prescribed in the regional strategy;
- Ensure active and meaningful participation of key population groups in the design and implementation of the regional strategy at national and sub-national levels; and
- Mobilise governmental and non-governmental organisations, civil society organisations and other stakeholders around a set of proven strategies based on their comparative advantages.

Human rights barriers to comprehensive HIV and Sexual and Reproductive Health (SRH) for key populations

Examples of human rights violations against LGBTI people[80]

LGBTI people experience violations of their human rights, such as the right to equality and non-discrimination and the rights to life and health. The table opposite sets out key rights available to all persons and looks at how human rights violations impact on access to SRHR for LGBTI people in the context of HIV.

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[80] *ARASA and others, Sexual orientation, gender identity, HIV and Human Rights: an advocacy toolkit, 2015, https://hivlawcommission.org/wp-content/uploads/2017/06/ARASA_Toolkit_full_web.pdf*

Human right	Where do we find them	How are LGBTI peoples' rights violated?
Equality and non-discrimination	ICCPR Article 2 & 26 ICESCR Article 2 African Charter Article 2, 3 and 18(3)	Laws that criminalise same sex sexual conduct violate rights to equality and non-discrimination.
Right to life	ICCPR Article 6 African Charter Article 4	LGBTI individuals face violence in their daily lives. Some may be murdered because of their sexual orientation and gender identity. Laws prescribing the death penalty for same sex sexual conduct violate the right to life.
Right to be free from arbitrary deprivation of liberty	ICCPR Article 9 African Charter Article 5	Where police arrest and detain LGBTI persons due to actual or perceived sexual orientation and/or gender identity, even in the absence of a criminal offence, they violate this right.
Right to be free from torture and cruel, inhuman and degrading treatment	ICCPR Article 7 African Charter Article 5	LGBTI persons often experience degrading treatment at health facilities and cruel treatment within custody and correctional facilities. Gay men and transgender people may be subjected to humiliating examinations by law enforcement officials to "prove" acts of homosexuality or gender identity
Right to bodily integrity	CCPR Article 7, 9, 17 African Charter Article 4	LGBTI persons often face violence, including sexual violence, at the hands of law enforcement officials and private citizens because of their actual or perceived sexual orientation and/or gender identity.
Right to privacy	ICCPR Article 17	Laws that criminalise consensual adult sexual conduct violate privacy rights
Right to health	ICESCR Article 12 African Charter Article 4	In many countries, LGBTI populations do not have accessible, available, appropriate and quality sexual and reproductive health care services
Right to freedom of association	CCPR Article 22 African Charter Article 10	LGBTI persons have a right to form organisations, gather socially and undertake joint activism to promote their human rights. However, in many countries organisations are denied the right to register, offices are raided and members are arrested on various charges linked to sexual offence laws.
Right to work	ICESCR Article 7 African Charter Article 15	Everyone has the right to the enjoyment of just and favourable conditions of work. LGBTI persons are denied employment at times, on the basis of their perceived or actual sexual orientation or gender identity.
Right to education	ICESCR Article 13 African Charter Article 17	LGBTI persons may be denied educational opportunities on the basis of their sexual orientation and/or gender identity. Sexuality education within schools also often fails to include information on sexual orientation and gender identity.
Right to self-determination	ICCPR Article 1 ICESCR Article 1 African Charter Article 22	Everyone has the right to pursue their economic, social and cultural development. LGBTI persons are denied this right when relationships, organisations and education opportunities, amongst other things, are denied to them.

Criminalisation and lack of an enabling legal environment

Laws that criminalise consensual sex between adults make it harder for gay men and other men who have sex with men, transgender people and sex workers to protect themselves from HIV and STIs and undermines their access to HIV-related services and sexual and reproductive health care. Laws that inappropriately criminalise non-disclosure, exposure and transmission of HIV also undermine the ability of key populations from seeking information and services related to HIV and their SRH. These laws create particular barriers to HIV prevention and testing.

For more information about HIV transmission, exposure and non-disclosure, please see factsheet eleven

As of 2015, at least half of SADC countries have laws that criminalise homosexuality, sex work and all SADC countries criminalise aspects of drug use and possession.

Country[81]	Criminalises sex between men	Criminalises sex work or aspects of sex work
Angola	X	X
Botswana	X	X
Democratic Republic of Congo (DRC)	No specific law but can be prosecuted under indecent assault	X
Lesotho		X
Madagascar		X
Malawi	Law is currently under review	X
Mozambique	X	X
Namibia	X	X
Seychelles	X	X
South Africa		X
Swaziland	X	X
Tanzania	X	X
Zambia	X	X
Zimbabwe	X	X

Stigma and discrimination

Key populations experience double stigma and discrimination: they are discriminated against on the grounds of their HIV or perceived HIV status and because they are part of a key population that is associated with sex, drug use and other controversial issues.

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[81] *ARASA, HIV, TB and Human Rights in Southern and East Africa Report, 2016, http://www.arasa.info/files/3314/8119/1044/ARASA_2016_Human_Rights_report.pdf*

Stigma and discrimination not only increase vulnerability to HIV, they also deter key populations from seeking out services and many choose to hide their sexual orientation, gender identity or the fact that they are sex workers, from health care workers, further undermining their access to appropriate health care. Transgender people experience particularly high levels of stigma and discrimination in multiple settings, including their homes, schools, the workplace and health facilities.

For more information on stigma and discrimination in health settings, see factsheet eight.

Violence

Key populations are at high risk of violence, including sexual violence. Criminalisation of their behaviours and stigma and discrimination increase their risk of violence and leave them without access to remedies for abuses and crimes committed against them.

Sex workers are at risk of violence from clients, sexual partners, police officers and other officials from the criminal justice system. Because sex work is criminalised, few sex workers report abuse to the police and this impunity may fuel further violence against them. Their criminalised status may deter them from seeking post rape care, including PEP to reduce the risk of HIV transmission.

Lack of access to health services and other programmes

Key populations have complex health needs, but frequently struggle to get access to appropriate and essential HIV and sexual and reproductive health care and most key populations in Africa use services tailored for the general population. Transgender people are particularly neglected in national AIDS responses and health care workers lack training and information about the health needs of transgender people.

There are few programmes in SADC countries that place key populations at the centre of the AIDS response. The 2017 UNAIDS report on key populations in Southern and East Africa indicates that at least four key populations, men who have sex with men, sex workers, people who use drugs and transgender people, “largely lack access” to essential prevention and treatment services. The WHO recommends the provision of comprehensive HIV services, including access to condom and lubricant, harm reduction interventions for substance use, behavioural interventions, routine HIV testing services, HIV treatment and care (including management of co-morbidities), PrEP and SRH interventions.[82]

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[82] *UNAIDS, Towards Ending AIDS in Eastern and Southern African Region: Leaving no one behind, a focus on sex workers, men who have sex with men, people who inject drugs and transgender people, 2017, http://www.ehpsa.org/all-documents/general/revhivprev/revitalising-hiv-prevention/2017/2-regional-synthesis-four-populations-left-behind-for-the-esa-region/brochure/336-brouchure-from-the-regional-syntheis/file*

WHO Guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014

These guidelines, the first on key populations, focus on five key populations: gay men and other men who have sex with men, people who use injecting drugs, people in prisons and other closed settings, sex workers and transgender people.

The Guidelines are based on the following principles:

- The human rights of key populations must be protected;
- Everyone has the right to access quality healthcare, free from discrimination;
- Access to justice is particularly important for people from key populations;
- Interventions to reduce the burden of HIV among key populations must be respectful and acceptable to recipients as well as appropriate and affordable for them;
- People from key populations require accurate health and treatment information to enable their decision-making
- Integrated service provision is needed to meet the other health challenges and poor social situations experienced by many people from key populations.[83]

What can parliamentarians do to advance the SRHR of key populations?

Parliamentarians have a particularly important role to play in helping to end stigma of key populations in all spheres of life, including in access to health care, social services and employment. They can promote laws, policies, practices and programmes that favour the integration of key populations in society and allow them to take an equal part in the political and socio-economic development of their countries. They can also advocate for the development of a standard regional package of effective, evidence based, voluntary, community - empowering SRH and HIV prevention, treatment and care services for key populations.[84]

Undertake advocacy research: Parliamentarians can initiate research into how HIV affects key populations in their countries, the impact of laws criminalising key populations and the extent to which the rights of key populations are being violated. By understanding the dynamics in their own countries, parliamentarians can encourage evidence based policies and programming for key populations. Parliamentarians can investigate how discriminatory laws and policies prevent health care workers and

[83] *HIV/AIDS Alliance, GNP+, STOP AIDS NOW, HIV and Key Populations, 2015, http://www.gnpplus.net/assets/wbb_file_updown/4810/Community%20Guide_I_HIV%20and%20key%20populations.pdf*

[84] *SADC, SADC Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations, 2017*

CSOs from delivering services to key populations and accessing funding to do so. Parliamentarians can also initiate research into special programmes that promote access to sexual and reproductive information, including on HIV prevention, to key populations.

Enacting and strengthening protective laws: Parliamentarians can draft, reform and enact laws to ensure they promote equality and non-discrimination for key populations and their access to sexual and reproductive health care and HIV-related services. They can ensure that laws:

- Promote equality for key populations and prohibit discrimination against them, including on the grounds of health and HIV status, employment and SOGI;
- Prohibit hate crimes on the basis of SOGI;
- Do not criminalise consensual adult sex and repeal laws that directly or indirectly discriminate on the grounds of SOGI;
- Do not criminalise any aspect of gender identity and sexual orientation, and repeal laws that directly or indirectly discriminate on the grounds of gender identity and sexual orientation;
- Recognise sex work as work;
- Allow transgender people to change gender markers;
- Promote equal, non-discriminatory access to sexual and reproductive health information, including HIV-related services, for key populations; and
- Respect the right to medical confidentiality for key populations.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments and do not hamper SRHR for key populations. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance equality for key populations and to protect them from violations of their human rights. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enact protective ones, and they can encourage civil society to monitor whether protective laws are being implemented.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to advance universal access to SRHR for key populations. They can analyse budget allocations for SRH and HIV-related services to assess whether programmes are tailored to reach and meet the needs of key populations. They can advocate for various ministries (e.g. health, education, justice) to budget for specialised programmes aimed at key populations, and advocate that human rights are fully integrated into programmes and appropriately costed to ensure implementation.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the importance of promoting the health and rights of key populations. By meeting publicly with members of key populations and speaking out in support of the rights of key populations, parliamentarians can help to discourage homophobia and stigma and discrimination. If they are willing to do so, gay, lesbian or transgender parliamentarians and parliamentarians living with HIV can publicly disclose this information and be role models for others. They can attend events and speak out to frame abuses against key populations as human rights violations and promote access to justice for key populations when their rights have been violated. They can use international or national human rights days such as International Sex Workers Rights Day (March 10), International Day Against Homophobia and Transphobia (May 17) and Transgender Remembrance Day (November 20) to increase awareness about the rights of key populations and their vulnerability to HIV. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness and share lessons learned amongst fellow parliamentarians at national, regional and global levels.

Engage with civil society: Parliamentarians can engage with CSOs, health care workers and groups led by and working with key populations to increase awareness, understanding and information on the SRHR of key populations, including access to HIV services. Parliamentarians can help to support key populations to advocate for their rights by inviting them to provide expert information/testimonies at parliamentary hearings on the impact of stigma and discrimination on vulnerability to HIV, the barriers created by criminalisation and other discriminatory laws and policies to sexual and reproductive health care and HIV-related services and other challenges to realising their human rights. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can support the development and strengthening of key population-led organisations and can play an important role in ensuring that the voices of key populations can influence all aspects of planning, including design, implementation and monitoring of national AIDS responses and SRH services.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including key populations. They can engage with key stakeholders within communities – key populations, women, health care workers, parents, traditional leaders and religious leaders, to increase awareness to about the sexual and reproductive health and rights of key populations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on the SRHR of key populations, including the disproportionate impact of HIV on this group. They can encourage the media to write stories that sensitively and accurately convey the reality of key populations and without judgment, provide relevant and reliable information about the SRHR needs of key populations.

References

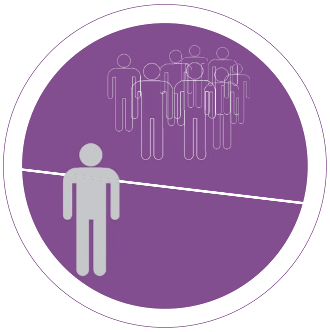
ARASA and others, Sexual orientation, gender identity, HIV and Human Rights: an advocacy toolkit, 2015
https://hivlawcommission.org/wp-content/uploads/2017/06/ARASA_Toolkit_full_web.pdf

HIV/AIDS Alliance, GNP+, STOP AIDS NOW, HIV and Key Populations, 2015
http://www.gnpplus.net/assets/wbb_file_updown/4810/Community%20Guide_I_HIV%20and%20key%20populations.pdf

UNAIDS, Guidance note on HIV and sex work, 2009
http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf

Stigma and discrimination in health care settings

Stigma and discrimination make people vulnerable to HIV and are critical barriers to HIV prevention, treatment, care and support and SRH care. UNAIDS recommends that all national AIDS responses include specific programmes to reduce stigma and discrimination: to ensure that they are effective, UNAIDS further recommends that seven key programmes are included in National Strategic Plans (NSP) and operational plans. The programmes should be appropriately costed, and indicators developed to monitor implementation and progress.[85]



Seven key programmes to reduce stigma and discrimination[86]

1. Programmes to reduce stigma and discrimination;
2. HIV-related legal services;
3. Monitoring and reforming laws, regulations and policies relating to HIV;
4. Legal literacy (Know Your Rights);
5. Sensitisation of law-makers and law enforcement lawmakers;
6. Training for health care providers on human rights and medical ethics related to HIV; and
7. Reducing stigma against women in the context of HIV.

People living with HIV experience stigma and discrimination on the grounds of their HIV status, but they may also experience additional stigma and discrimination on the basis of their sexual orientation, gender identity, drug use and sex work. Members of these key populations in turn may also experience stigma and discrimination on the basis of their HIV or perceived HIV status.

Although progress has been made in combatting stigma and discrimination, it is not enough and has been uneven in the health sector where inadequate attention has been paid to this issue.[87] UNAIDS reports that on average, one in eight people living with HIV reports being denied health services on the basis of their HIV status.[88]

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[85] *UNAIDS, Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses, guidance note 2012, http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf*

[86] *Ibid.*

[87] *Nyblade, L., and others, Combatting HIV stigma in health settings. What works?, Journal of the International AIDS Society, 2009:12: 15; http://jiasociety.biomedcentral.com/articles/10.1186/1758-2652-12-15*

[88] *UNAIDS, Eliminating discrimination in health care, Stepping stone to ending the AIDS epidemic, 2016, http://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-in-health-care_en.pdf*

Transgender people may be at particularly high risk of experiencing stigma and discrimination when they seek access to health care which affects their access to HIV treatment, care and support. Transgender people living with HIV face well-documented barriers to ART and have lower rates of adherence.
Stigma and discrimination in health care remains a persistent and serious concern and creates barriers to health care workers delivering quality services to patients and to the uptake and use of HIV prevention, care, treatment and support by patients.

Stigma and discrimination in health settings are driven by many factors, including negative attitudes about the sexuality of people living with HIV and key populations, lack of information about HIV transmission and health workers' own fear of becoming infected. Health care workers are critical to ensuring that people living with HIV and key populations have access to HIV prevention, treatment, care and support, as well as sexual and reproductive health care so that they can make informed decisions about sex, contraception and family planning.

Useful definitions

HIV-related stigma:[89] refers to the negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and key populations, such as people who inject drugs, sex workers, men who have sex with men and transgender people.

HIV-related discrimination:[90] refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. Discrimination in the context of HIV also includes the unfair treatment of key populations, such as sex workers, people who inject drugs, men who have sex with men and transgender people. HIV-related discrimination is usually based on stigmatising attitudes and beliefs about populations, behaviours, practices, sex, illness and death. Discrimination can be institutionalised through existing laws, policies and practices that negatively focus on people living with HIV and marginalised groups, including criminalised populations.

[89] *UNAIDS, Reduction of HIV-related stigma and discrimination, guidance note, 2014, http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf*

[90] *UNAIDS, Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses, guidance note 2012, http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf*

International and regional human rights obligations

The major international and regional human rights treaties prohibit discrimination and require governments to take steps to eliminate all forms of discrimination against individuals, including on the grounds of health and HIV status.

The Committee on Economic, Social and Cultural Rights states that access to health care should be based on the principle of non-discrimination, especially for the most vulnerable and marginalised groups.

In addition to their right to equality and non-discrimination, the right to the highest attainable standard of health is guaranteed under the African Charter on Human and People's Rights, ICESCR and the CEDAW. Key populations must be able to access the right to health care on a non-discriminatory basis.

States also have an obligation to ensure accountability and remedies when rights have been violated.

The agenda for zero discrimination in health care[91]

UNAIDS and WHO's Global Health Workforce Alliance launched the Agenda for Zero Discrimination in Health Care on 1 March 2016. The campaign works towards a world where everyone, everywhere, is able to receive the health care they need with no discrimination. The action plan underpinning the campaign has seven priorities:

- Remove legal and policy barriers that promote discrimination in health care.
- Set the standards for discrimination-free health care;
- Build and share the evidence base and best practices to eliminate discrimination in health-care settings;
- Empower clients and civil society to demand discrimination-free health care;
- Increase funding support for a discrimination-free health workforce;
- Secure the leadership of professional health-care associations in actions to shape a discrimination-free health workforce; and
- Strengthen mechanisms and frameworks for monitoring, evaluation and accountability for discrimination-free health care.

The 2016 Political Declaration on Ending AIDS reaffirms that state commitments include ensuring that health services comply with human rights standards, and that all forms of violence, discrimination and coercive practices in health-care settings are eliminated and prohibited. With respect to HIV, this includes that everyone has equal access to HIV prevention, treatment, care and

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[91] *UNAIDS, Agenda for Zero Discrimination in Health Care Settings, 2017, http://www.unaids.org/sites/default/files/media_asset/2017ZeroDiscriminationHealthCare.pdf*

support free from stigma and discrimination. Member States committed to addressing discrimination in health care, education and the workplace.

Impact of stigma and discrimination

There is a large body of research that shows that stigma and discrimination, or fear of being discriminated against or stigmatised, undermines universal access to HIV prevention, treatment, care and support. Internalised stigma is particularly pernicious, preventing people living with HIV and key populations from accessing available treatment and support and those at risk of HIV from taking steps to prevent transmission and remain HIV negative.

Stigma Index – questions on stigma in health facilities

The People Living with HIV Stigma Index is a tool that measures and detects changing trends in stigma and discrimination experienced by people living with HIV. The Stigma Index contains questions about respondents' experiences in accessing sexual and reproductive health care and information as well as accessing HIV testing and treatment and disclosing their HIV status – these reports are an excellent source of information about stigma in health care settings.

Ten SADC countries have already completed the Stigma Index: Botswana, the Democratic Republic of Congo (DRC), Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

A key reason for HIV-related stigma and discrimination relates to the fact that it is an STI and may also involve drug use and other behaviours that are criminalised. Not all health care workers are comfortable dealing with sex and sexuality and many are not appropriately trained to provide counselling, information and treatment to people living with HIV and key populations. In addition, health care workers are members of the communities they serve, and they often reflect the same stigma, especially towards key populations.

Stigma in hospitals, clinics and other health facilities shows up in different ways: key populations and people living with HIV or perceived to be living with HIV are denied care or receive delayed, sub-optimal care; patients experience breaches of their privacy, including disclosure of their HIV status without their consent; and they receive incomplete, inadequate or inaccurate information and cannot make informed decisions about their health. Health care workers may gossip about patients living with HIV, neglect their care and use gloves unnecessarily during interactions with patients. HIV-related discrimination includes HIV testing without informed consent, forced or coerced sterilisation of women living with HIV and isolation of patients.

Women and girls

Young women face judgmental attitudes from health care workers when they seek family planning information, access to contraception and HIV testing and counselling. There are too few adolescent-friendly clinics in Southern Africa that provide supportive and non-judgemental care and support.

For more information about adolescent girls and young women, see factsheet two.

Women living with HIV may be pressurised to end their pregnancies (where abortion is available), be sterilised without their consent or discouraged from having children. Pregnant women living with HIV are particularly vulnerable to stigma and discrimination when they are pregnant, in labour and while giving birth. They are often unable to get information about contraception, family planning and how to protect themselves and their partners.

Key populations

Key populations, including sex workers, injecting drug users, gay men and other men who have sex with men and transgender people often experience stigma and discrimination when they try to access HIV or sexual and reproductive health care. There is a dearth of health care providers who have the training to care for the sexual, reproductive and HIV-related needs of key populations. Few have received training on human rights, gender equality and the rights of key populations to receive quality health care and many do not feel confident discussing these issues with their patients.

For more information on key populations, see factsheet seven.

Criminalisation of same sex sex, drug use and sex work further stigmatise these groups and creates an environment that undermines their access to health care as health care workers may be confused and afraid about whether they can legally provide health care, including HIV prevention and treatment, to these groups, including counselling them on safer sex options, discussing their risk factors and providing condoms.

Rights of health care workers

A key part of reducing stigma and discrimination against people seeking HIV and SRH care is ensuring the rights of health care workers themselves are protected. Many health care workers work in contexts where they do not have access to universal precautions to protect themselves from HIV transmission and many lack information about modes of transmission which creates fear and leads to stigma and discrimination.

Universal precautions for the prevention of HIV transmission

Universal precautions are based an approach which treats all blood and certain bodily fluids (including semen and vaginal secretions) as though they are known to be infectious for HIV (and other blood borne pathogens).

Universal precautions involve the use of gloves and other barriers and the safe handling of needles, scalpels and other sharp instruments and good hygiene practices such as handwashing.

The needs of health workers living with HIV are often neglected: not all hospitals have policies in place to protect their rights to confidentiality and non-discrimination. Health care workers themselves may fear stigma and so do not seek HIV testing and treatment.

Training for health care providers on human rights and medical ethics related to HIV: one of the seven key programmes to reduce stigma

One of the seven key programmes recommended by UNAIDS to reduce stigma and discrimination focusses on health care workers and takes a two-pronged approach:

- Health care workers are trained to know their own rights to health and non-discrimination in the context of HIV; and
- Health care workers are provided with tools to ensure patients' human rights to confidentiality, informed consent, treatment and non-discrimination are respected. These skills help to reduce stigmatising attitudes amongst health care workers.

What can parliamentarians do to combat stigma and discrimination in health settings?

Undertake advocacy research: Parliamentarians can initiate research to assess that all NSPs include stigma reduction programmes; they can support community-led research on stigma and discrimination experienced by people living with HIV and key populations and in particular, they can support the use of the People Living with HIV Stigma Index; they can commission specific research on stigma and discrimination in health settings; and they can initiate research to assess whether there are specific laws and policies that prevent key populations from accessing health care.

Enact and strengthen protective laws: Parliamentarians can enact and draft laws protecting people living with HIV and key populations from discrimination, including in healthcare settings. They can:

- Promote anti-discrimination laws that protect people living with HIV and key populations from discrimination;
- Promote laws that protect women and girls from discrimination and protect them from violence;
- Promote equal, non-discriminatory access to HIV prevention, treatment, care and support and sexual and reproductive health care;
- Promote laws that decriminalise HIV transmission, sex work, drug use and same sex sexual conduct;
- Promote health laws that:
    - Do not require spousal or parental consent to access information and services about HIV prevention, treatment, care and support;
    - Do not require spousal or parental consent to access sexual and reproductive health care and information;
    - Respect the right to medical confidentiality and privacy for people living with HIV and key populations; and
- Promote CSE for adolescents and young men and women, including information about the risk of cervical cancer.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments and are working to reduce stigma and discrimination. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance equality for key populations and protect them from violations of their human rights. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance.

Budget monitoring: Parliamentarians can ensure that stigma reduction measures in NSPs are properly costed and that adequate budgetary provision is made for their implementation. They can encourage various ministries (e.g. health, education, justice) to budget for relevant programmes, including to train health care personnel (from doctors to nurses, health care assistants and attendants), especially those on the front lines, about dealing with key populations and people living with HIV.

Be an opinion leader and influencer: Parliamentarians can help raise awareness about stigma and discrimination against people living with HIV and key populations. Parliamentarians living with HIV or with family members living with HIV can speak out about their status and help to destigmatise HIV. They can become opinion leaders by publicly meeting with people living with HIV and key populations and speaking out about the need to protect their human rights, including their right to health. By speaking out, parliamentarians can help foster an enabling environment, including in health settings. They can attend events, deliver speeches and speak out to frame access to health care for people living with HIV as a human rights issue. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians. They can share lessons learned at regional and global level with other parliamentarians, including from outreach to communities on HIV.

Engage with civil society: Parliamentarians can engage with CSOs, including networks of people living with HIV and key populations, primary health care workers, health care workers, university medical schools, private practitioners and other groups working on HIV and SRH. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on stigma and discrimination in health care settings and work with these groups to promote stigma reduction programming and they can empower people living with HIV and key populations to advocate for themselves by inviting them to participate in these meetings. Parliamentarians can play an important role in ensuring the voices of people living with HIV and key populations are included in discussions about their lives.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate. Parliamentarians can engage with key stakeholders within communities – women, key populations, people living with HIV, health care workers, parents, traditional leaders and religious leaders, to increase awareness about stigma and discrimination. In particular, parliamentarians can ensure that they include the voices of people living with HIV and key populations at the centre of these conversations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage more reporting on access to healthcare for people living with HIV and key populations. They can encourage the media to write stories that frame access to health care as a human right and that document the barriers that people living with HIV and key populations experience when trying to access sexual and reproductive health care. They can also convey information about the challenges that health care workers face in providing sexual and reproductive health care to people living with HIV and key populations.

References

Nyblade, L., and others, Combatting HIV stigma in health settings. What works?, Journal of the International AIDS Society, 2009:12: 15
http://jiasociety.biomedcentral.com/articles/10.1186/1758-2652-12-15

The People Living with HIV Stigma Index
http://www.stigmaindex.org/

UNAIDS, Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses, guidance note 2012
http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf

factsheet 9

Prevention

The scale-up of ART is one of the most significant achievements in the struggle against HIV, but it has not been matched by similar progress in HIV prevention. No country was able to meet the target of reducing sexual and drug-related transmission by 50% in 2015, as set out in the 2011 UN Political Declaration on HIV/AIDS. In October 2017, UNAIDS released its *HIV Prevention 2020 Road Map*.[92] The Road Map is intended to guide the scale-up of national prevention programmes and assist countries to meet the 2030 HIV targets.

2020 Road Map's five prevention pillars

1. Combination prevention for adolescent girls, young women and their male partners in high prevalence settings;
2. Combination programmes for all key populations;
3. Strengthened national condom and related behavioural change programmes;
4. Voluntary medical male circumcision; and
5. PrEP to populations at substantive risk.

Although a 29% decline in new HIV infections has been reported in Southern and East Africa between 2010 and 2016, this decline is uneven between countries and population groups.[93] One third of all new infections in the region in 2016 were in South Africa and an additional 50% occurred in Kenya, Malawi, Mozambique, Uganda, Tanzania, Zambia and Zimbabwe.[94] Key populations, including sex workers, gay men and men who have sex with men, transgender persons, and people who use drugs, also continue to have disproportionately high rates of HIV infection and access to services does not meet the demand.[95] The 2017 *SADC Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights amongst Key Populations* confirms the high levels of both HIV prevalence and risk for key populations and the urgent need to address their access to HIV prevention.

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[92] *UNAIDS, HIV Prevention 2020 Road Map, 2017, http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf*

[93] *UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017, http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf*

[95] *UNAIDS, Towards Ending AIDS in Eastern and Southern African Region: Leaving no one behind, a focus on sex workers, men who have sex with men, people who inject drugs and transgender people, 2017, http://www.ehpsa.org/all-documents/general/revhivprev/revitalising-hiv-prevention/2017/2-regional-synthesis-four-populations-left-behind-for-the-esa-region/brochure/336-brouchure-from-the-regional-syntheis/file*

Various groups are being left behind:

- The HIV epidemic in Southern and East Africa continues to disproportionately affect women and girls, with young women (aged 15–24 years) accounting for 26% of new and GBV block access to HIV prevention services and young women and girls do not have access to CSE to allow them to make informed decisions about how to protect themselves from HIV, nor can they always decide when or whether to have sex. Laws and policies that require parental consent to HIV testing and access to SRH care may further undermine prevention efforts.

For more information about adolescent girls and young women, see factsheet two.

- Gender inequality and GBV increase women's vulnerability to HIV and undermine their access to HIV prevention services and commodities, including HIV testing and counselling. Women in abusive relationships cannot make decisions about protecting themselves from HIV and they are often afraid to undergo HIV testing, access ART or disclose their HIV status to a sexual partner. Adolescent girls and young women are especially vulnerable to domestic violence and in Africa, many girls report that their first sexual experience was coercive.

For more information about the sexual and reproductive health and rights of women living with HIV, see factsheet one.

- Stigma and discrimination, including criminalisation of consensual adult sex, help to block access to HIV prevention information, services and commodities for key populations and high levels of sexual violence contribute to their increased vulnerability to HIV.

For more information about key populations, see factsheet seven.

Useful definitions

Combination prevention approach: UNAIDS recommends that countries adopt an approach that provides packages of services, including biomedical, structural and behavioural components, tailored to priority populations in their local contexts.[96]

Biomedical interventions: interventions that use clinical and medical methods e.g. condoms and lubricants, ART as prevention, PrEP, voluntary medical male circumcision, needle and syringe programmes.

Structural interventions: these interventions promote an enabling environment, including decriminalising sex work, drug use and homosexuality, addressing gender inequality and GBV, promoting the rights of people living with HIV and key populations and reducing stigma.

Behavioural interventions: focus on encouraging safe behaviour including risk reduction counselling, CSE, peer education and social marketing campaigns.[97]

What is combination prevention?

Combination prevention programmes are rights-based, evidence- informed and community-led and they seek the best ways to reduce new infections amongst individuals and communities. They combine biomedical, structural and behaviour interventions into a single integrated response tailored to the local context.[98]

The 2016 Prevention Gap Report states that too few countries are applying a combination prevention approach to HIV.[99]

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[96] *UNAIDS, Prevention Gap Report, 2016, http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf*

[97] *International HIV/AIDS Alliance, Advancing HIV combination prevention: an advocacy brief for community led organisations, 2016, http://www.aidsalliance.org/assets/000/002/472/web_AllianceUnaids_Comb_prevention_original.pdf?1459762561*

[98] *International HIV/AIDS Alliance, Advancing HIV combination prevention: an advocacy brief for community led organizations, 2016, http://www.aidsalliance.org/assets/000/002/472/web_AllianceUnaids_Comb_prevention_original.pdf?1459762561*

[99] *UNAIDS, Prevention Gap Report, 2016, http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf*

International and regional human rights obligations

International human rights law has been interpreted to obligate states to ensure access to condoms and other HIV prevention services, as part of the right to the highest attainable standard of health. ICESCR directs governments to take steps necessary for the prevention, treatment and control of epidemics. This would include HIV.

Laws and policies that undermine access to HIV prevention services and commodities, including needle and syringe exchange programmes and harm reduction information, including through criminalisation, may infringe on the right to health.

The UN Human Rights Council adopted its sixth resolution on the protection of human rights in the context of HIV and AIDS in 2011. The resolution confirmed that prevention should be at the core of national, regional and international responses to HIV and include:

- Reducing risk taking behaviours and encouraging responsible sexual behaviour;
- Expanding access to male and female condoms and sterile injecting equipment; and
- Providing age appropriate sexuality education to children and young people.

The CSW adopted a 2016 resolution on women, girls and HIV that recognises the impact of gender inequality, harmful practices and violence on women and girls' vulnerability to HIV. The resolution calls on government to intensify their efforts to achieve gender equality and eliminate violence against women and girls and to reduce barriers to their participation in HIV prevention. The resolution also calls on governments to enable young women and men to protect themselves from HIV infection by enabling their use of male and female condoms, PEP and PrEP.

In addition to their legal obligations under international and regional human rights laws, SADC countries have also committed to achieve the SDGs, also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. Goal 3 deals with health and well-being and one of the targets for measuring this goal is the eradication of the AIDS epidemic by 2030.

The 2016 UN General Assembly Political Declaration on Ending AIDS recognises the gaps in prevention and obliges states to provide comprehensive prevention services for all women, girls and key populations, including by:

- Providing non-discriminatory HIV-prevention efforts by "taking all measures to implement comprehensive, evidence-based prevention approaches to reduce new infections";

- Scaling up "scientifically accurate age appropriate comprehensive education, relevant to cultural contexts" to adolescent girls and boys, young women and men and in and out of school youth about SRH, HIV prevention, gender equality, women's empowerment, human rights, physical, psychological and pubertal development and power in relationships between women and men; and

- Providing tailored prevention interventions, including male and female condoms, voluntary medical male circumcision and efforts to minimise the public health and social consequences of drug abuse.

2020 prevention targets in the 2016 Political Declaration

- Ensure that financial resources for prevention constitute no less than a quarter of AIDS spending globally on average;
- 90% of those at risk of HIV are reached by comprehensive prevention services based on the following 5 programme targets:

1. Reach 90% of young women, adolescent girls and their male partners and reduce the number of new infections amongst adolescent girls and young women to below 100 000;
2. Reach 90% of key populations with evidence and human rights-based prevention programmes;
3. Make 20 billion condoms available in low and middle-income countries annually;
4. Reach an additional 25 million young men in high HIV incidence countries with voluntary male medical circumcision; and
5. Reach 3 million people at higher risk of HIV with PrEP.

The Declaration also sets regional prevention targets for prevention: in Southern and East Africa, countries commit to reducing the number of new infections amongst young people and adults by 75% to 210 000.

Human rights barriers to key prevention services

Lack of access to male and female condoms

Condoms are central to HIV prevention efforts and an estimated 45 million HIV infections have been prevented since 1990 through condom usage.[100] However, the demand for condoms far outweighs supply, and several groups struggle even more than the general public to gain access to condoms:

- There is a dearth of female condoms available in sub-Saharan Africa and few women and girls have consistent access to them.

[100] *UNAIDS, Prevention Gap Report, 2016, http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf*

- In many African countries, laws, regulations and/or policies prevent the distribution of condoms in prisons. Even where condoms are available in prisons, lubricant is rarely provided.
- Criminalisation of consensual adult sex hampers condom distribution to gay men and other men who have sex with men and sex workers, especially when possession of condoms may be used as evidence of unlawful sexual activity by the police and expose key populations to prosecution, fines and/or imprisonment. In some countries, governments also refuse to supply lubricant for men who have sex with men and accuse organisations who supply lubricants to men who have sex with men of promoting homosexuality.

Priority populations: SADC's condom fast-track target setting meeting, October 2017

SADC has identified priority populations for condom distribution:

- People living with HIV;
- Sex workers and their clients and regular partners;
- Men who have sex with men and transgender persons and their regular and non-regular partners;
- Persons with disabilities and their regular and non-regular partners;
- Women and men with non-regular partners;
- Sexually active, non-married adolescent girls and young women and their regular and non-regular partners; and
- Couples who use condoms for family planning.

Harm reduction for people who use drugs

People using drugs are extremely vulnerable to HIV infection – the 2016 Gap report suggests they are 24 times more likely to be infected with HIV than members of the general population. The package of harm-reduction services for injecting drug use is well known and includes needle and syringe exchange programmes (to reduce not only the spread of HIV, but also hepatitis C and other blood borne diseases) and opioid substitution therapy. Few SADC countries are providing these services consistently, if at all.

Criminalisation, stigma and discrimination prevent people who use drugs from accessing HIV prevention information, services and commodities that are tailored to their needs, and in some countries, possession of needles and syringes may be seen as evidence of drug use, further undermining efforts by people who use drugs to protect themselves from HIV.

Suppression of viral load

People with undetectable viral loads are far less likely to transmit HIV to their sexual partners. Treatment adherence is crucial to viral load suppression. While the scale-up of ART is one of the successes of the international AIDS response, there are inequalities to access, especially for key populations and access to viral load testing is limited in resource poor settings.

What can parliamentarians do to advance HIV prevention?

Parliamentarians can champion prevention plans and targets, and advocate for the prevention needs of the most vulnerable and marginalised people, including women, girls and key populations. They can advocate for governments to adopt and implement the 10-point plan in the 2020 Prevention Road Map. They can play a particularly important role in creating a conducive policy and legal environment to promote evidence-informed and human rights based prevention programmes.

Undertake advocacy research: Parliamentarians can initiate research into the barriers to HIV prevention, particularly for key populations and adolescent girls and young women. It is important to understand the reasons why people are not accessing HIV prevention services as reasons will differ between countries and by understanding the dynamics in their own countries, parliamentarians could encourage evidence-based policies and programming. Parliamentarians can investigate the availability of HIV prevention services and commodities in public health facilities, whether health care workers have been trained to advise and deliver CSE, including prevention services and testing for key populations and adolescents and young people. Parliamentarians can also initiate research into special programmes that promote HIV prevention for key populations and women, including young women, women with disabilities, adolescent girls and women displaced by conflict and natural disasters.

Enact and strengthen protective laws: Parliamentarians can draft and enact laws that support comprehensive HIV prevention efforts. They can ensure that laws:

- Promote equality and prohibit discrimination;
- Promote gender equality and prohibit and punish GBV;
- Do not punish drug users for being in possession of drugs for personal use;
- Do not criminalise consensual adult sex, including same sex conduct and sex work, and repeal laws that criminalise or discriminate against sex workers, gay men and other men who have sex with men;
- Do not prevent the distribution of condoms and lubricant to prisoners, sex workers and other at-risk populations;
- Promote equal, non-discriminatory access to HIV prevention information, services and commodities;
- Do not require spousal or parental consent to access HIV prevention information, services or commodities;
- Do not promote coercive approaches to prevention, including mandatory HIV testing and criminalisation of harm reduction;
- Respect the right to medical confidentiality for everyone, including women and girls and members of key populations; and
- Promote CSE for adolescents and young men and women, including information about HIV prevention.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments and do not hamper access to HIV prevention. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws and assess what changes are necessary to advance access to HIV prevention information, services and commodities. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures to advance HIV prevention information, services and commodities: UNAIDS recommends that 25% of HIV budgets should be allocated to primary prevention programming.[101] They can analyse budget allocations for HIV prevention to assess that programmes will reach women, including young women, and key populations. They can also analyse budget allocation for condom promotion, which is typically under-funded. They can encourage various ministries (e.g. health, education, justice) to budget for relevant programmes and that human rights are fully integrated into programmes on contraception and appropriately costed to ensure implemented.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the importance of HIV prevention and encourage debate about prevention programmes that is based on scientific evidence and best practices, and not shaped by stigma. By speaking out, parliamentarians can encourage the recognition of the specific prevention needs of key populations and encourage a human rights-based approach to HIV prevention. They can attend events and speak out to advocate and frame HIV prevention as a human rights issue. They can use international or national human rights days to increase awareness about the importance of HIV prevention. They can also work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with CSOs, including key populations organisations, youth groups, health care workers and other groups working on various aspects of HIV prevention. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on the barriers to HIV prevention and empower members of key groups to advocate on their own behalf. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can play an important role in ensuring that the voices of key groups are included in discussions about their lives and that they can influence all aspects of planning, including design, implementation and monitoring, of HIV prevention interventions. Thus, they can ensure and apply best practices of a participatory democracy.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including marginalised and vulnerable groups. Parliamentarians can engage with key stakeholders within communities – key populations, health care workers, parents, traditional leaders

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[101] *UNAIDS, HIV Prevention 2020 Road Map, 2017, http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf*

and religious leaders, to increase awareness to about HIV prevention and human rights barriers to access.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage responsible reporting on prevention. They can encourage the media to write stories that provide accurate and reliable information about HIV transmission and HIV prevention interventions.

References

International HIV/AIDS Alliance, Advancing HIV combination prevention: an advocacy brief for community led organisations, 2016
http://www.aidsalliance.org/assets/000/002/472/web_AllianceUnaids_Comb_prevention_original.pdf?1459762561

UNAIDS, HIV Prevention 2020 Road Map, 2017
http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf

UNAIDS, Prevention Gap Report, 2016
http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf

UNAIDS, On the Fast-Track to end AIDS, strategy 2016 – 2021
http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017
http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf

factsheet 10

Treatment

ART was initially unaffordable for most people living with HIV in Africa, and large numbers of AIDS deaths occurred in the early years of the epidemic. The past decade has seen dramatic increases in the numbers of people who have access to ART: by 2011, the global target of 15 X 15, namely 15 million people on treatment by 2015, was already met and exceeded. UNAIDS reported that by the end of 2016, 19.5 million people were accessing ART.[102]

Despite this important progress, the 2016 UN *Political Declaration on HIV and AIDS: On the FastTrack to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030*, cautions against complacency and expresses “grave concern” that 22 million, or three out of five people living with HIV do not have access to ART.

The 2017 Global AIDS Epidemic Update indicates that Southern and East Africa has “made huge strides towards meeting the 90-90-90 targets”: 76% of people living with HIV know their status; 79% of people living with HIV who know their status are on treatment and 83% of people on treatment are virally suppressed.[103]

Six out of ten people on ART now live in Southern and East Africa and approximately 60% of all people living with HIV in the region are on treatment (this equates to 11.7 million people). In 2016, 67% of women and 51% of men above the age of 15 were accessing treatment.[104] The increase in access to ART has cut AIDS-related deaths by half in the region.

People living with HIV are more vulnerable to Tuberculosis (TB) and hepatitis B and C: people living with HIV account for 13% of all people with TB and TB remains one of the biggest killers of people living with HIV. The 2014 UNAIDS Gap Report indicates that two to four million people living with HIV are co-infected with hepatitis B, while four to five million have hepatitis C. More needs to be done to ensure access, not only to ART, but to TB (including drug resistant TB) and hepatitis medicines.

[102] *UNAIDS, Global HIV Statistics, 2017, http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf*
[103] *UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017, http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf*
[104] *UNAIDS, Global HIV Statistics, 2017, http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf*

Useful definitions

Routine Viral Load Testing (RVLT) is the most accurate way of measuring the number of copies of HIV in the body.[105]

Treatment adherence: for ART to work, people on treatment need to follow strict adherence which means taking their medication every day at the same time, or as prescribed by their health care provider. Poor adherence can be caused when people on treatment do not take their pills at the same time every day, when they forget a dose or when they stop taking some or all of their medication. Poor adherence can also be caused by stigma and discrimination.

International and regional human rights obligations

Access to ART, TB and hepatitis medicines is an essential part of every person's human rights to life and health and governments have a duty to protect and promote these rights under international and regional human rights treaties.

The right to health is enshrined in various international and regional treaties, including the ICESCR, the CEDAW, the CRC, the African Charter on Human and Peoples' Rights, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (the Maputo Protocol) and the African Charter on the Rights and Welfare of the Child.

The right to health includes states' obligations to "ensure that medicines are available, financially affordable, and physically accessible on a basis of non-discrimination to everyone".[106] This means that all governments must take steps, as part of their duty to promote and protect the right to the highest attainable standard of health, to promote broad access to safe, effective and affordable medicines, including ART and treatment for TB and hepatitis.

The UN Human Rights Council adopted a landmark resolution in 2016 reaffirming that the right to health includes access to affordable medicines of good quality in a timely fashion. The resolution was adopted by consensus, although the European Union and other Western countries raised many objections to the language. It calls for international co-operation to assist developing countries to promote the right to health, including through access to medicines, and for innovative funding mechanisms that will contribute to the availability of vaccines and medicines in developing countries.

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[105] *ITPC, Activist Toolkit, Campaigning for Routine Viral Load Monitoring, 2017, http://itpcglobal.org/wp-content/uploads/2016/05/ITPC-RVLT-Toolkit-English.pdf*

[106] *UN Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, 2009, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G09/127/11/PDF/G0912711.pdf?OpenElement*

Access to ART and intellectual property rights

The cost of medicines remains one of the most significant barriers to access to medicines in Africa, where countries still import most of their essential drugs.

In order to meet their human rights obligations to protect and promote the right to health, SADC countries must create an enabling legal and policy framework that helps to increase access to medicines. Intellectual property laws and trade rules set out by the World Trade Organization (WTO) and in terms of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement have created barriers to affordable medicines in Africa. Intellectual property laws give market exclusivity (through e.g. patents) to companies that develop medicines, allowing them to charge high prices on the basis of their investment in research and development.

In 2001, WTO members[107] adopted the Doha Declaration on the TRIPS Agreement and Public Health, reiterating that least developed countries were able to use the "flexibilities" within TRIPS to increase access to affordable medicines – such as generic medicines - for public health reasons. Since then, WTO members have adopted a number of additional, related decisions to implement the Declaration.

Most African countries have incorporated intellectual property protections in their domestic laws, including harmonising their patent laws to protect patents on medicines, but very few countries have become TRIPS compliant or have taken full advantage of TRIPS flexibilities to increase access to affordable medicines.

The 2016 UN resolution on access to medicines emphasises the primacy of human rights over international trade, investment and intellectual property regimes and the obligation of all states to ensure non-discriminatory access to medicines. It urges States to take full advantage of TRIP flexibilities. It promotes the use of affordable medicines, including generics.

Parliamentarians should be familiar with TRIPS flexibilities, such as compulsory licensing and parallel importing, and able to review intellectual property laws to ensure those flexibilities are used.

In addition to their legal obligations under international human rights laws, SADC countries have also committed to achieve the SDGs, also known as the Global Goals. These goals aim to end extreme poverty, eliminate inequality and injustice and address climate change by 2030. Goal 3 deals with health and target 3.3 aims to end the HIV and TB epidemics, by 2030. The indicators for this target include reducing new HIV, TB and hepatitis B infections.

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[107] *All SADC countries are members of the WTO*

Human rights barriers to ART

People living with HIV face barriers to both starting ART early enough and to treatment adherence.

Treatment adherence among young people is generally lower than the general population and treatment failure rates are comparatively higher, especially among adolescents who are transitioning from paediatric to adult care. Studies in Kenya, Uganda and Tanzania indicate that young people aged 15 - 19 years are more likely to drop out of HIV care, both before and after starting ART, than are those aged 10 - 14 years or those older than 20 years. Studies suggest that stigma, discrimination and disclosure issues, as well as travel and waiting times at clinics, are among the reasons.108

Stigma and discrimination

Stigma and discrimination and fear of stigma and discrimination prevent many people living with HIV from accessing ART and TB treatment. Key populations living with HIV experience double stigma which affects their access to treatment. There are currently no reliable estimates of the numbers of people living with HIV who are also gay men or other men who have sex with men, sex workers, injecting drug users or transgender and who are accessing ART, but the 2014 UNAIDS treatment progress report for Africa states there “are strong indications that key populations face substantial barriers to accessing essential health services and have extremely low access to antiretroviral therapy”.109

Discriminatory laws and policies, including laws that criminalise HIV transmission, sex work, same sex sexual conduct and drug use, drive people away from HIV related services and may make it difficult for health care workers to know what services they may legally provide to sex workers, gay men and other men who have sex with men and people who inject drugs. Health care workers may themselves stigmatise key populations and thereby undermine their access to ART.

For more information on stigma and discrimination in health settings, see factsheet eight.

Gender-based abuses

High levels of violence against women and girls, including domestic violence and other gender based violations, affect women and girls’ access to HIV testing and treatment and their adherence to ART. Fear of violence and abandonment discourages women from seeking and accessing HIV testing and sexual and reproductive health care, placing their health at risk. Fear of violence may force women to hide their HIV status from their sexual partners which can undermine treatment adherence. Poverty, which disproportionately affects women and girls, may force them to miss appointments at hospitals and clinics and they may run out of ART and miss doses.

Women and girls also struggle to access comprehensive SRH care which in turn undermines their access to ART.

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[108] *UNICEF, For Every Child, End AIDS: Seventh Stocktaking Report, 2016, https://www.unicef.org/publications/files/Children_and_AIDS_Seventh_Stocktaking_Report_2016_EN.pdf.pdf*

[109] *UNAIDS, Access to antiretroviral therapy in Africa, status report on progress towards the 2015 targets, 2014, http://www.unaids.org/sites/default/files/media_asset/20131219_AccessARTAfricaStatusReportProgresstowards2015Targets_en_0.pdf*

Lack of access to HIV and viral load testing

HIV testing is a key access point to ART, and yet more than half of people living with HIV do not know their HIV status. Key populations experience particular challenges accessing HIV testing, counselling and information and there are too few programmes that target their specific needs for HIV counselling and testing. Research shows that in some countries, including in SADC, less than half of key populations know their HIV status. Adolescents and young people also struggle to access HIV testing. The 2017 Global AIDS Update states that "large proportions of young people living with HIV have not been diagnosed." Studies conducted in Malawi, Zambia and Zimbabwe indicate that less than half young people living with HIV know their status.[110]

The Stigma Index reports show that fear of HIV-related stigma and discrimination causes many people to delay or avoid having an HIV test.

For more information on adolescent girls and young women, see factsheet two.

For more information on key populations, see factsheet seven.

Access to routine viral load testing

Monitoring ART is an essential part of access to treatment. The most effective way to monitor the effectiveness of ART is through RVLT which has been routinely used in high-income settings for many years. RVLT is however not freely available in SADC countries and many people living with HIV do not have access to regular viral load monitoring or cannot afford it where it is available.

The goal of ART is to reduce the viral load in your body so that you have as few copies of HIV in your blood as possible, achieving viral suppression. Ideally there should be so few copies of HIV in your blood that they cannot be detected by a viral load test, resulting in an undetectable viral load. A low or undetectable viral load is a strong indication that ART is working, but it also reduces the risk of HIV transmission.

In October 2015, ARASA and the International Treatment Preparedness Coalition (ITPC) launched the *Be Healthy, Know your Viral Load* campaign. The ongoing campaign aims to inform people living with HIV about the value of viral load testing, to mobilise people to demand routine viral load testing and to urge governments to make sure the tests are routinely available, accessible and affordable. [111]

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[110] *UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017, http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf*

[111] *ITPC, Activist Toolkit, Campaigning for Routine Viral Load Monitoring, 2017, http://itpcglobal.org/wp-content/uploads/2016/05/ITPC-RVLT-Toolkit-English.pdf*

Lack of targeted services for key and vulnerable populations

ART is a lifelong commitment and people living with HIV who are on treatment require supportive health and other services to help them to adhere to treatment and achieve viral suppression.[112] Key populations may face particular challenges with adherence to both ART and TB medicines: people living with HIV who use injecting drugs are more likely to adhere to ART and TB if they can also access opioid substitution therapy (OSI) and other harm reduction services – these are however not readily accessible in SADC countries; adolescents living with HIV often struggle to access sexual and reproductive health care and information, including because of a lack of trained counsellors that can assist with their particular adherence challenges.

What can parliamentarians do to advance access to treatment?

Undertake advocacy research: Parliamentarians can initiate research into human rights barriers to treatment in their countries. They can call for a legal audit to determine whether the laws in their countries incorporate and use TRIPS flexibilities to expand access to affordable medicines. They can also call for research to help them better understand the intellectual property regime of their country and assess whether patent protection is stricter than is required by the Doha Declaration. They can investigate what positions their countries have taken in previous trade negotiations to assess whether they have entered into agreements that are inconsistent with TRIPS flexibilities. They can commission research into what information is collected on access to treatment for key populations.

Enact and strengthen protective laws: Parliamentarians can draft and enact laws that promote access to treatment, including for key populations. They can ensure that laws:

- Provide for confidential HIV testing with informed consent and counselling;
- Promote equal, non-discriminatory access to HIV and TB medicines for all persons;
- Respect the right to medical confidentiality for all persons;
- Promote CSE for adolescents and young men and women;
- Do not criminalise HIV transmission, exposure and/or non-disclosure, consensual adult sex or any form of gender identity;
- Do not require parental consent for access to information and services related to contraception, STI treatment, HIV counselling and testing, HIV treatment and abortion and post-abortion care for adolescents; and
- Incorporate TRIPS flexibilities into domestic laws on intellectual property in order to increase access to HIV, TB and hepatitis medicines, including affordable generics.

[112] *UNAIDS Guidance note, Fast-Track and human rights, advancing human rights in efforts to accelerate the response to HIV, 2017, http://www.unaids.org/sites/default/files/media_asset/JC2895_Fast-Track%20and%20human%20rights_Print.pdf*

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which laws and policies are consistent with their international and regional human rights commitments to promote access to ART, TB and hepatitis medicines. They can meet with the relevant parliamentary committees to share information and concerns about the barriers to affordable medicines, including for key populations. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws, including those that criminalise HIV transmission and any form of consensual adult sex, enact protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments. Parliamentarians can encourage government to develop national plans of action, with clear targets, milestones, indicators and allocated budgets, to achieve SDG Target 3.3 on ending the HIV and TB epidemics by 2030. They can monitor and hold government ministries accountable for reporting on their progress and achievements to expand access to ART. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments.

Budget monitoring: Parliamentarians can work to identify gaps in funding for treatment and can advocate to address these, and for adequate budgets to be allocated to expand access to affordable medications, including for HIV, TB and hepatitis. They can analyse budget allocations for HIV and TB programmes and SRH to assess that programmes will reach key populations. They can work with their constituents to ensure that funding for treatment reaches sub-national and local levels.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the importance of HIV, TB and hepatitis medicines and they can help to frame access to treatment as a human right. They can attend events and speak out to educate the public about the importance of treatment, highlight the barriers to treatment and support treatment literacy programmes. They can work within Parliament and in Parliamentary forums and networks, to raise awareness amongst fellow parliamentarians about access to treatment and the role of parliamentarians in expanding access. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with CSOs to increase awareness, understanding and information on HIV, TB and hepatitis treatment. Parliamentarians can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on access to treatment as a human right, barriers to access, including for key populations and any challenges to access within the legal framework. They can empower key populations to advocate on their own behalf. They can present the findings of these meetings and hearings to relevant government ministries. Parliamentarians can play an important role in ensuring that the voices of people living with HIV, women and key populations can influence all aspects of planning, including design, implementation and monitoring of national treatment plans.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including people living with HIV and key populations. Parliamentarians can engage with key stakeholders within communities – people living with HIV, key populations, young people, teachers, parents, traditional leaders, religious leaders and health workers, to increase treatment literacy and build support for access to treatment in their communities. They can visit health facilities in their constituencies and gather information about the challenges people living with HIV face in accessing ART.

Work with the media: Parliamentarians can work with the media to raise awareness about how stigma and discrimination undermines access to treatment; they can work with journalists to place stories that highlight how access to treatment can improve the quality of life of people living with HIV and the importance of adherence.

References

UNAIDS, Access to antiretroviral therapy in Africa, status report on progress towards the 2015 targets, 2014
http://www.unaids.org/sites/default/files/media_asset/20131219_AccessARTAfricaStatusReportProgresstowards2015Targets_en_0.pdf

UNAIDS Guidance note, Fast-Track and human rights, advancing human rights in efforts to accelerate the response to HIV, 2017
http://www.unaids.org/sites/default/files/media_asset/JC2895_Fast-Track%20and%20human%20rights_Print.pdf

UNAIDS, Ending AIDS, Progress Towards The 90-90-90 Targets, Global AIDS Update, 2017
http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf

UNAIDS, The Gap Report, 2014
http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

factsheet 10

Criminalisation of HIV transmission, exposure and non-disclosure

Over the past decades, several African countries introduced specific legislation to criminalise HIV transmission, exposure and non-disclosure. These laws were and are often passed because parliamentarians and others believe they will help curb the spread of HIV and better protect women and girls. Many of these laws are poorly drafted, vague and/or over-broad, raising serious human rights and public health concerns.[113]

Activists and public health experts have long agreed that criminalising HIV transmission, exposure and non-disclosure undermines universal access to HIV prevention, treatment, care and support and infringes on the human rights of people living with HIV. A key concern in many jurisdictions is how the criminal justice system has ignored or overlooked the most reliable and up-to-date scientific and medical evidence on HIV transmission. Legal provisions criminalising HIV transmission, exposure and non-disclosure are rarely updated to take into account medical advances and laws are therefore based on outdated and incorrect information. A stark illustration of the failure of law to keep pace with scientific and medical knowledge is the failure to acknowledge that people living with HIV with undetectable viral loads are extremely unlikely to transmit the virus.

The 2012 Global Commission on HIV and the Law[114] found that HIV criminalisation is fundamentally unjust, morally harmful, and virtually impossible to enforce with any semblance of fairness. The Commission also found that these laws impose regimes of surveillance and punishment on the intimate relations and reproductive and maternal lives of sexually active people living with HIV, isolates them and discourages them from getting tested, participating in prevention or treatment programmes or disclosing their status to partners. The Commission recommended that countries not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status and that countries amend or repeal any law that explicitly or effectively criminalises vertical transmission of HIV.

In 2013, UNAIDS issued updated guidance, *'Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations'*, on how to end inappropriate criminalisation and reiterated that no evidence exists showing that criminalisation is an effective tool to halt the spread of HIV.[115]

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[113] UNAIDS, Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf

[114] www.hivlawcommission.org

[115] Ibid.

It is important to recognise that the human rights and public health concerns about HIV criminalisation do not undermine the ability of governments to ensure that any person who maliciously and deliberately transmits HIV can be prosecuted – existing general criminal laws are sufficient to deal with these rare cases. The 2013 UNAIDS guidance sets out the appropriate use of the criminal law in the context of HIV, namely that it should be limited to cases of intentional transmission. "i.e. where a person knows his or her HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it."[116]

International and regional human rights obligations

Various international and regional treaties contain provisions that obligate countries to take steps to protect, promote and fulfil the right to health, including SRHR. The African Charter on Human and People's Rights, the Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol) and the CEDAW all contain provisions that oblige countries to take steps to progressively realise the right to SRH. The ICESCR provides that all states must take the necessary steps to prevent, treat and control epidemic, endemic, occupational and other diseases and create conditions so that everyone has access to medical services and attention in the event of sickness.

The Committee on Economic Social and Cultural Rights has interpreted the right to SRH to include an obligation to eliminate discrimination against individuals and groups. This includes repealing laws that impair individuals' ability to realise their rights to SRH because of the criminalisation of HIV non-disclosure, exposure and transmission. In addition, the committee stated that countries cannot "limit or deny" anyone access to SRH and must reform laws that impede their access.[117]

Guideline 4 of the *International Guidelines on HIV/AIDS and Human Rights* states that governments should review criminal laws to ensure they are consistent with human rights and that they are not misused in the context of HIV. The guideline states that criminal laws should not include "specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases."[118]

The 2001 *Declaration of Commitment on HIV/AIDS* committed governments to "enact, strengthen or enforce" laws and other measures to eliminate all forms of discrimination against people living with HIV and vulnerable groups and ensure their access to health care and social and health services.[119] The 2016 *Political Declaration on HIV and AIDS* reinforced this commitment and explicitly urged states to review and reform all legislation that "may create barriers or reinforce stigma and discrimination such as … laws related to HIV non-disclosure, exposure and transmission."[120]

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[116] Ibid.

[117] UN Economic and Social Council, Committee on Economic, Social and Cultural Rights, General Comment no 22 (2016) on the right to sexual and reproductive health, 2016, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11

[118] UNAIDS, International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, http://data.unaids.org/publications/irc-pub07/jc1252-internguidelines_en.pdf

[119] UN General Assembly, Declaration of Commitment on HIV/AIDS, 2001, http://www.unaids.org/sites/default/files/sub_landing/files/aids-declaration_en_0.pdf

[120] UN General Assembly, Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight Against HIV and to End the AIDS Epidemic by 2030, 2016, http://www.hlm2016aids.unaids.org/wp-content/uploads/2016/06/2016-political-declaration-HIV-AIDS_en.pdf

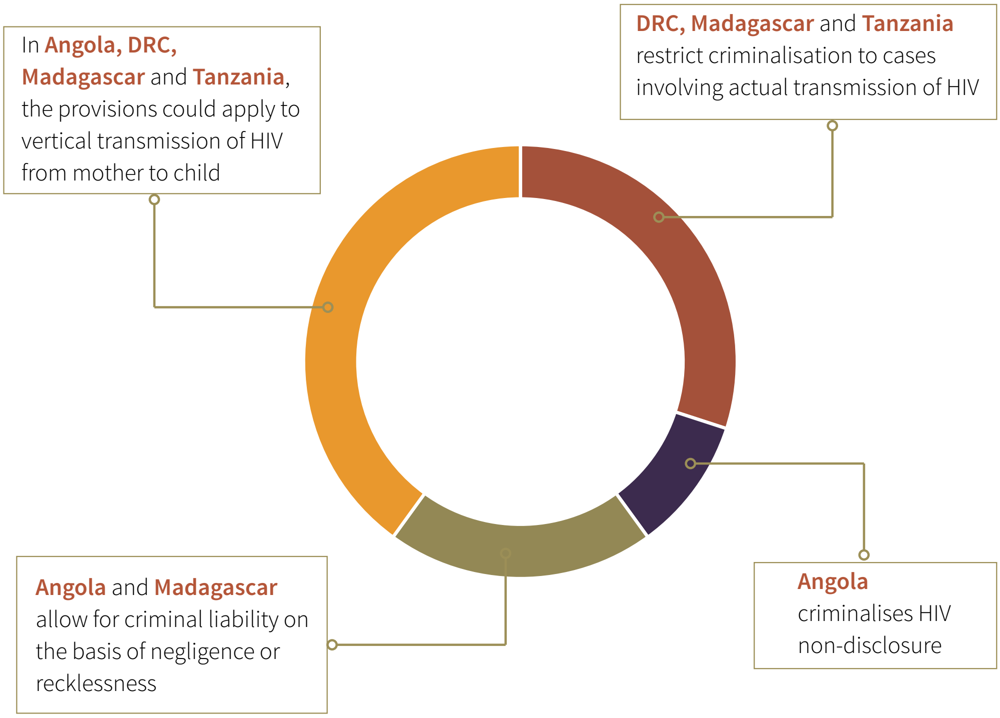
UNAIDS' 2013 guidance on ending inappropriate criminalisation sets out key principles that should guide the use of the criminal law in dealing with harmful HIV-related behavior, namely:

- It should be guided by the best available scientific and medical evidence relating to HIV;
- It should uphold the principles of legal and judicial fairness; and
- It should protect the human rights of those involved in criminal law cases.

SADC-PF and criminalisation

In recognition of the potential role that parliamentarians and lawmaking could play in combatting the epidemic, the SADC-PF adopted a model law on HIV in Southern Africa in 2008. The model law explicitly recognises and promotes a human rights-based and gender sensitive approach to HIV and does not include provisions criminalising HIV transmission.

In 2015, the SADC-PF adopted a motion on the criminalisation of HIV transmission, exposure and non-disclosure that acknowledges that specific laws criminalising HIV are harmful to HIV prevention, treatment and care and undermine human rights. The motion calls on states to review harmful HIV-specific laws and enact laws that support evidence based HIV prevention and treatment that are consistent with human rights standards.



In **Angola, DRC, Madagascar** and **Tanzania**, the provisions could apply to vertical transmission of HIV from mother to child

DRC, Madagascar and **Tanzania** restrict criminalisation to cases involving actual transmission of HIV

Angola and **Madagascar** allow for criminal liability on the basis of negligence or recklessness

Angola criminalises HIV non-disclosure

Criminalisation of HIV transmission, exposure and non-disclosure in SADC countries

The table below shows the current state of criminalisation in the SADC.

Countries	Criminalises non-disclosure	Criminalises HIV exposure	Criminalises HIV transmission
Angola	Yes	No	Yes
Botswana	No	No	No
Democratic Republic of Congo (DRC)	No	No	Yes
Lesotho	Yes	No	No
Madagascar	No	No	Yes
Malawi	No	No	No
Mauritius	No	No	No
Mozambique	No	No	No
Namibia	No	No	No
Seychelles	No	No	No
South Africa	No	No	No
Swaziland	No	No	No
Tanzania	No	No	Yes
Zambia	Yes	Yes	Yes
Zimbabwe	No	Yes	Yes

A recent review of HIV-specific laws in sub-Saharan Africa in terms of the 2013 UNAIDS guidance found that:[121]

- Three SADC countries (DRC, Madagascar and Tanzania) restrict criminalisation to cases involving actual transmission of HIV;
- One country (Angola) criminalises HIV non-disclosure;
- Two countries (Angola and Madagascar) allow for criminal liability on the basis of negligence or recklessness; and
- In four countries (Angola, DRC, Madagascar and Tanzania), the provisions could apply to vertical transmission of HIV from mother to child.

Currently, no SADC countries exclude criminal liability where a condom is used or the person living with HIV has a low viral load.

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[121] *ARASA, HIV, TB and Human Rights in Southern and East Africa Report, 2016, http://www.arasa.info/files/3314/8119/1044/ARASA_2016_Human_Rights_report.pdf*

Human rights consequences of criminalisation

Criminalisation undermines HIV prevention and testing

People may be discouraged from seeking out HIV testing if they are afraid that knowing their HIV status could force them to disclose it to their sexual partners and expose them to prosecution if they fail to do so. In some countries where HIV transmission is criminalised, a lack of knowledge of one's HIV status is a defence in a criminal case, further disincentivising people from HIV testing.[122]

Criminalisation also undermines important public health messages about prevention, namely that the responsibility to protect oneself from HIV transmission lies with both sexual partners, and not just the person living with HIV.[123]

It undermines the relationship between people living with HIV and health care workers

Laws that criminalise HIV non-disclosure, exposure and transmission not only have a chilling effect on people living with HIV seeking health services in the first place; they also undermine existing relationships between health care workers and their patients living with HIV. People living with HIV may fear that health care workers will be obliged to provide information about their HIV status and that information may be used against them in the criminal justice system. A lack of trust between patients living with HIV and health care workers may impact on the quality of care.

Women are disproportionately vulnerable to criminalisation

Criminalisation is often framed as a tool to protect women and girls from HIV, but it is in fact more likely to lead to their prosecution. Women often learn about their HIV status before their male partners as they are tested in ante-natal clinics and/or because they are more likely to seek out health services.

Women, including women living with HIV, are not always able to refuse sex or insist that their sexual partners use condoms. Disclosing their HIV status to sexual partners can also expose them to the risk of violence, disinheritance, loss of their children and abandonment. HIV criminalisation may place women in an impossible situation: forcing them to "risk violence by trying to protect their partners or to risk prosecution by failing to do so."[124]

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[122] *Open Society Institute, 10 Reasons to Oppose the Criminalisation of HIV Exposure or Transmission, 2008, https://www.opensociety-foundations.org/sites/default/files/10reasons_20081201.pdf*

[123] *UNAIDS and UNDP, Policy Brief: Criminalisation of HIV Transmission, http://www.unaids.org/sites/default/files/media_asset/jc1601_policy_brief_criminalisation_long_en.pdf*

[124] *Ibid., 10 Reasons to Oppose the Criminalisation of HIV Exposure or Transmission*

What can parliamentarians do to end inappropriate criminalisation of HIV transmission, exposure and non-disclosure?

Parliamentarians can play an important role in ensuring that criminal laws are appropriately used in the context of HIV transmission, exposure and/or non-disclosure. They should give careful consideration to the circumstances of when it is appropriate to use the criminal law and the negative consequences of HIV criminalisation, including stigmatising people living with HIV, discouraging HIV testing, creating a false sense of security amongst people who are HIV-negative and imposing a disproportionate burden on women.[125]

Undertake advocacy research: Parliamentarians can initiate research into the adverse impact of criminalising HIV transmission, exposure and non-disclosure on human rights and public health, including access to HIV prevention, treatment, care and support. They can investigate whether legal services are available to people living with HIV who are at risk of being charged with an HIV-related offence and they can investigate what laws, policies and programmes can help reduce HIV-related stigma and help more people safely disclose their HIV status.

Enact and strengthen protective laws: Parliamentarians draft and enact laws that create an enabling environment for people living with HIV by strengthening laws promoting human rights and repealing HIV-specific laws that criminalise transmission, exposure or non-disclosure. They can ensure that laws:

- Promote equality and non-discrimination for people living with HIV and key populations;
- Allow for prosecution for cases of HIV transmission only when they involve intentional transmission;
- Are informed by the best available medical and scientific evidence relating to HIV and modes of transmission, prevention and treatment;
- Clarify the rights and responsibilities of people living with HIV under the law through prosecutorial and police guidelines to ensure that police investigations into possible cases of intentional transmission are appropriately conducted;
- Protect, promote and fulfil the right to equality and non-discrimination for all women and girls, including those living with HIV;
- Criminalise all forms of GBV, including marital rape; and
- Respect the right to medical confidentiality for everyone, including if it relates to HIV status.

Ensure accountability for implementation of commitments: Parliamentarians can undertake legal audits to assess the extent to which criminal laws and policies are consistent with international and regional human rights commitments. They can meet with the relevant parliamentary committees to share information and concerns about discriminatory laws, including HIV-specific criminal laws, and assess what changes are necessary to ensure that criminal laws are consistent with

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[125] *1st Global Parliamentary Meeting on HIV/AIDS, December 2007, Manila, Philippines.*

human rights obligations. They can meet with international and regional experts to discuss what law reform is necessary and advocate for legal and policy reform to ensure compliance. They can monitor and hold government ministries accountable for reporting on their progress towards amending discriminatory laws and enacting protective ones, and they can encourage civil society to monitor whether protective laws are being implemented. Where they find deficits, they can advocate for legal and policy reform to ensure compliance. Parliamentarians can monitor and hold government ministries accountable for reporting on their progress. They can also call for accountability to and reporting on efforts to meet related international and regional human rights commitments.

Budget monitoring: Parliamentarians can advocate for adequate budgets to be allocated for measures such as the inclusive development of police and prosecutorial guidelines and the training of police, prosecutors, magistrates and judges on how to apply the criminal law in the context of HIV. They can encourage various ministries (e.g. health, justice) to budget for relevant programmes and to ensure that human rights are fully integrated into programmes.

Be an opinion leader and influencer: Parliamentarians can become opinion leaders on the harms of criminalising HIV transmission, exposure and non-disclosure through HIV specific laws. By speaking out, parliamentarians can help to build an enabling environment for people living with HIV that allows them to access HIV testing, treatment and support and to safely disclose their HIV status. They can attend events and speak out to frame criminalisation as a human rights and public health issue. They can use international or national human rights days, including World AIDS Day (1 December) and International Human Rights Day (10 December) to increase awareness about the human rights of people living with HIV. They can work within parliament and in parliamentary forums and networks, to raise awareness about the harms of criminalisation amongst fellow parliamentarians and ensure that they have the best and most up to date medical and scientific information about HIV prevention and treatment. They can share lessons learned at regional and global level with other parliamentarians.

Engage with civil society: Parliamentarians can engage with CSOs, including those led by people living with HIV, health care workers and other groups working on women's rights, violence against women, HIV and sexual and reproductive rights to increase awareness, understanding and information on the harms of criminalisation of HIV transmission, exposure and non-disclosure. They can invite CSOs and the communities they work with, to provide expert information at parliamentary hearings on criminalisation and they can seek their expertise in developing prosecutorial and police guidelines. Parliamentarians can play an important role in ensuring that the voices of key populations and women and girls living with HIV, who are likely to be disproportionately affected by criminalisation, are included in discussions about their lives and help to empower women and girls living with HIV to advocate on their own behalf.

Represent their electorate: Parliamentarians should engage with and reflect the concerns of all their electorate, including people living with HIV. They can engage with key stakeholders within communities – people living with HIV, including women, health care workers, traditional leaders and religious leaders, to increase awareness about the human rights and HIV criminalisation. In particular, parliamentarians can ensure that they include the voices of girls and women living with HIV at the centre of these conversations.

Work with the media: Parliamentarians can work with the media to raise awareness and to encourage reporting about HIV transmission that relies on the most up to date information about HIV prevention and transmission, that explains the difficulties of safely disclosing HIV status and the importance of shared responsibility for SRH. Parliamentarians can explain that sensationalised reporting on criminalisation reinforces stigma and discrimination and does not help reduce the spread of HIV. Parliamentarians can advocate for training for the media on how to report on HIV and HIV criminalisation in ways that protect the human rights of people living with HIV.

References

HIV Justice Network and the Global Network of People Living with HIV, Advancing HIV Justice 2: Building Momentum in Global Advocacy against HIV Criminalisation, 2016
http://www.hivjustice.net/advancing2/

Open Society Institute, HIV Justice Toolkit to Support Advocacy Against HIV Criminalisation
http://www.hivjustice.net/news/hiv-justice-toolkit-to-support-advocacy-against-hiv-criminalisation-now-online/

Open Society Institute, 10 Reasons to Oppose the Criminalisation of HIV Exposure or Transmission, 2008
https://www.opensocietyfoundations.org/sites/default/files/10reasons_20081201.pdf

UNAIDS, Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations, available at:
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf

UNAIDS, International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version
http://data.unaids.org/publications/irc-pub07/jc1252-internguidelines_en.pdf

Checklists and tools

Checklist 1:	International and regional human rights commitments
Checklist 2:	The 2016 United Nations Political Declaration on HIV and AIDS
Checklist 3:	The Sustainable Development Goals
Checklist 4:	Law making
Tool 1:	How to organise an inclusive parliamentary hearing on HIV and SRHR
Tool 2:	Sample parliamentary questions
Tool 3:	Joint parliamentary committee on HIV and SRHR

checklist 1

International and regional human rights commitments

Governments now recognise that protecting and promoting the human rights of people living with HIV and key populations is an essential part of combatting HIV. Parliamentarians have a crucial role to play ensuring that governments respect their international, regional and national commitments on HIV and SRHR.

International and regional human rights instruments often have dedicated committees for conducting periodic country reviews and monitoring progress. Countries submit state reports and CSOs and other organisations submit shadow reports to the committees. Some committees are also entrusted with the task of handling individual complaints and their decisions are persuasive.

Ratifying the regional and international human rights framework

There are currently no international human rights instruments that explicitly address HIV. However, treaty monitoring bodies and national courts have interpreted key provisions of various international treaties including the rights to life, dignity, privacy, equality, health and education, to provide protection to people living with HIV.

What is ratification?

This is the process in terms of which a State signs the treaty and thereby expresses its consent to be bound by the provisions of that treaty.

Parliamentarians can ensure that their governments have ratified key international treaties such as the following, and that they are fulfilling their obligations:

- International Covenant on Civil and Political Rights (ICCPR);
- International Covenant on Economic Social and Cultural Rights (ICESCR);
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);
- Convention on the Rights of the Child (CRC); and
- Convention on the Rights of Persons with Disabilities (CRPD).

To check whether your country has ratified these international instruments, see: http://indicators.ohchr.org/

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) is the only regional instrument that includes a reference to HIV.

Parliamentarians can ensure that their governments have ratified key regional human rights instruments, including:

- African Charter on Human and People's Rights;
- The Maputo Protocol; and
- The African Charter on the Rights and Welfare of the African Child.

To check whether your country has ratified these international instruments, see https://au.int/web/en/treaties?field_treaty_signedby_tid_i18n%5B%5D=15&=Apply

The 2016 United Nations Political Declaration on HIV and AIDS

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 2016 declaration, signed in June 2016, commits countries to work towards eradicating HIV by 2030.

Gaps in the Political Declaration

Civil society criticised the Declaration for its weakness on the HIV-related needs of key populations. Many groups felt that the Declaration failed to adequately address the concerns of those most at risk of HIV.

Further, the Declaration calls for laws, policies and practices that enable access to services and help end stigma and discrimination, but does not explicitly call for the decriminalisation of consensual adult sex or drug use. A civil society declaration urged the United Nations and governments to endorse and follow ten steps to end the AIDS epidemic.[126]

Parliamentarians have a role to play in holding governments accountable for the promises they have made in the Declaration. They can help ensure that progress reports are properly prepared and that civil society, especially people living with HIV and key populations, are meaningfully involved in the process.

Global commitments in the 2016 Political Declaration:

Countries re-committed to the following 2020 targets:

- Reduce new HIV infections to less than 500 000 per annum by 2020;
- Reduce AIDS-related deaths to less than 500 000 per annum by 2020; and
- Eliminate stigma and discrimination.

In addition, countries committed to 10 goals to eradicate HIV by 2030 and should report to UNAIDS on progress to achieve these:

1. Ensure that 30 million people have access to ART by 2020;
2. Eliminate new infections amongst children by 2020 and ensure that 1.6 million children have access to ART by 2018;
3. Ensure access to combination prevention options, including PrEP, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations - gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners;

[126] *ICASO, Civil Societies and Communities Declaration to end HIV: Human Rights Must Come First, June 2016, http://www.icaso.org/announcements/civil-society-and-communities-declaration-to-end-hiv-human-rights-must-come-first*

4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020;
5. Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year;
6. Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020;
7. Ensure that at least 30% of all service delivery is community-led by 2020;
8. Ensure that HIV investments increase to US$26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers;
9. Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights; and
10. Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for TB, cervical cancer and hepatitis B and C.

Regional commitments for East and Southern Africa: 2020

- Reduce the number of new HIV infections in adults and young people to 210 000;
- Reduce the number of new HIV infections amongst children to 9 400;
- Increase the number of people on treatment to 14.1 million; and
- Increase the number of children on treatment to 690 000.

Checklist for parliamentarians on developing the country progress reports on the implementation of the 2016 Political Declaration on HIV and AIDS:

- Does your country provide an Annual Country Progress report to UNAIDS?
- Do you know which government department is responsible for preparing the report?
- Do you know the timing for the report?
- Does parliament participate in the preparation of the Country Progress Report?
- Is there a parliamentary focal point on HIV? Does it have the necessary expertise and staffing to participate in the preparation of the Country Progress Report?
- Do other parliamentary committees such as those on women, health and children, participate in the preparation of the report?
- If your government does not prepare or regularly prepare a Country Progress Report, can parliament encourage it to do so?
- What role does parliament play in engaging civil society in the preparation of the Annual country progress report?
- Does parliament have effective partnerships with key populations and people living with HIV, and is it able to ensure that their voices are included in the preparation of the country progress report?
- Does parliament have access to the necessary expertise (clinicians, public health experts, economists, civil society) to seek advice on government programmes and responses?

To see what reports your country has submitted to UNAIDS, go to: http://www.unaids.org/en/regionscountries/countries?utm_source=unaids-en-mainmenu&utm_medium=direct

checklist 3

Sustainable Development Goals (SDGs): Goals 3 and 5

Countries are encouraged to conduct regular reviews of their progress towards achieving the SDGs and to involve civil society in the process. The UN High Level Political Forum meets every July to take stock of global and national progress. The reviews, called Voluntary National Reviews (VNRs) aim to share information between countries about the challenges, successes and lessons learned in the implementation of the SDGs. In addition, States are also encouraged to update or develop national development plans to set their own priorities and decide how to use the SDG targets and indicators in their national contexts.

For more information about the VNRs and to see whether your country has reported, go to: https://sustainabledevelopment.un.org/hlpf#vnrs

SDGs 3 and 5 are particularly important for addressing HIV and SRHR-related challenges.

3 GOOD HEALTH AND WELL-BEING

SDG 3 promotes healthy lives and well-being for all, at all ages

Goal 3 includes several targets relevant to HIV and sexual and reproductive health:

- End the epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030;
- Ensure universal access to sexual and reproductive health-care services by 2030;
- Ensure universal health coverage (including financial risk protection, access to quality essential health care and safe, effective, quality and affordable essential medicines and vaccines);
- Support the research and development of vaccines and medicines for diseases that primarily affect developing countries, provide access to affordable medicines and vaccines in accordance with the Doha Declaration; and
- Increase health financing and the recruitment, development, training and retention of health care workers in developing countries.

5 GENDER EQUALITY

SGD 5 presses for the achievement of gender equality and the empowerment of all women and girls

Goal 5 sets out several targets that are relevant to HIV and sexual and reproductive health:

- End all forms of discrimination against women and girls;
- Eliminate violence against women and girls;
- Eliminate harmful practices against women and girls (including child marriage);
- Recognise and value unpaid care and domestic work;
- Ensure universal access to sexual and reproductive health and rights; and
- Make reforms to give women equal rights to economic resources.

Parliamentarians can play a critical role in monitoring government progress on the SDGs and hold governments accountable for progress.

Checklist for parliamentarians to hold governments accountable for the SGDs in relation to HIV and SRHR:

- Are you familiar with the SDGs, their targets and indicators?
- Is information about the SGDs and the role of parliamentarians included in briefing materials for new parliamentarians?
- Have you received any training on the SDGs? If not, can you arrange for seminars and other opportunities to provide parliamentarians with information that will allow them to fulfil their monitoring role?
- Is there a working group or parliamentary committee with a formal mandate on monitoring the SDGs?
- Has your parliament had a plenary debate on how the SDGs relate to your context?
- Has your country established an SDG working group? Does it include parliamentary representation?
- Has your government developed a national action plan for the implementation of the SDGs? If so, did parliament endorse it? If not, can you ask it to do so and facilitate public participation in the process?
- Has parliament undertaken a review to assess whether any laws need to be passed or amended to support the SDGs?
- Has your country taken part in a VNR?
- Was the report tabled in parliament for discussion?
- What were the recommendations for further action on implementing the SDGs? Where they tabled in parliament for discussion?
- Have parliamentarians received briefings from civil society on the HIV and sexual and reproductive health components of the SDGs?
- Are the SDGs, in particular SDGs 3 and 5, sufficiently integrated into budget programmes of the State?

Lawmaking

In their capacity as lawmakers, Parliamentarians have a very important role to play in designing, adopting and amending laws that advance the human rights of people living with HIV, those affected by it and key populations. Parliamentarians can scrutinise all new laws to make sure that they do not undermine human rights or hamper access to SRH services and effective HIV prevention, treatment, care and support.

They can also review existing laws to make sure that they do not discriminate against people living with HIV, those affected by it and key populations or promote stigma that undermines access to SRH services and effective HIV prevention, treatment, care and support. Where they find discrimination, they can work to reform and amend laws.

International Guidelines on HIV/AIDS and Human Rights

The International Guidelines on HIV/AIDS and Human Rights provide guidance for policy and lawmakers on how best to promote human rights in the context of the HIV epidemic. They emphasise the important role law plays in protecting the rights of people living with HIV and people vulnerable to HIV infection.

The Guidelines specifically require States to review and reform laws to ensure that they adequately address the human rights dimensions of the epidemic.

Several guidelines provide detailed guidance to lawmakers on law reform and the enactment of protective laws:

- **Guideline 3:** States should **review and reform public health laws** to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV, and that they are consistent with international human rights obligations.
- **Guideline 6:** States should **enact legislation to provide for the regulation of HIV-related goods, services and information,** so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including ART and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both domestic and international levels, paying particular attention to vulnerable individuals and populations.

Checklist for parliamentarians to hold governments accountable for implementing the International Guidelines on HIV/AIDS and Human Rights:

Public health

- Are there laws that require that HIV testing be performed with the informed consent of the person to be tested and only after they have received the necessary information to allow them to make an informed decision?
- Are there laws that provide for pre- and post-test HIV counselling?
- Are there laws that prohibit mandatory HIV testing, including of prisoners, pregnant women, adolescents, sex workers and other vulnerable groups?
- Are there laws or policies that protect the right to medical confidentiality, including for adolescents?
- Are there laws or policies that prohibit disclosure of medical information, including HIV status, without the prior informed consent of the patient?
- If there are laws or policies that allow for the disclosure of HIV and STI status to sexual partners, are they consistent with international standards (see text box)?

Disclosure of HIV status to a sexual partner

Guideline 3 of the International Guidelines on HIV/AIDS and Human Rights sets out a list of criteria to assist health care workers to decide whether to inform a sexual partner of a patient's HIV status and how to do so ethically:

- The person living with HIV has been "thoroughly counselled";
- Counselling has failed to achieve appropriate behavioural changes;
- The person living with HIV has refused to notify, or consent to the notification of his/her partner(s);
- There is a real risk of HIV transmission to the partner(s);
- The person living with HIV is given reasonable advance notice that disclosure will take place;
- The identity of the person living with HIV is concealed from the partner(s), if possible;
- Follow-up care and support is provided to those involved, as necessary.

- Are there laws that protect people from coercive health measures e.g. sterilisation without informed consent, mandatory HIV testing and involuntary disclosure of HIV status?
- Are there laws or policies that require parental consent to HIV testing, access to information about sexual and reproductive health and contraception and other services and commodities for adolescents? Are these laws in conflict with laws determining the age of consent for sexual intercourse?
- Are there laws and policies that criminalise any forms of preventing pregnancy?
- Is abortion criminalised? Are there specific circumstances under which abortion is legal in your country? Is access to post-abortion care criminalised?

- Are there laws and policies that mandate the provision of post-rape treatment and care, including emergency contraception and PEP, particularly to women, girls and key populations?
- Are there laws or policies that permit people to have access to their own health records?
- Are there laws or policies that mandate the provision of universal precautions in health settings and other places involving the exposure to blood and bodily fluids? Do the laws or policies also require that health care workers, including those working in prisons, and anyone else who may be exposed to blood or other bodily fluids be trained to implement universal precautions and provided with the necessary equipment?
- Are there laws or policies that require health care workers to have training on human rights?

Criminal law

Guidelines 4: States should **review and reform criminal laws and correctional systems** to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

- Does the criminal law include provisions that undermine access to universal HIV prevention, treatment, care and support services?
- Is HIV transmission, exposure or non-disclosure specifically criminalised?
- Are there laws that criminalise consensual sex between adults, including sex work and same sex sexual conduct?
- Are there laws or policies that prohibit or undermine the provision of sexual and reproductive health care, including HIV prevention information, services and commodities, to people engaging in criminalised activities?
- Is drug possession or possession of needles criminalised?
- Are there laws or policies that prohibit or undermine the provision of harm reduction services, including needle and syringe exchange and opioid substation therapy to people who use drugs?
- Are there laws or policies that prohibit the distribution of condoms and lubricant to gay men, other men who have sex with men or prisoners?

Anti- discrimination laws

Guideline 5: States should **enact or strengthen anti-discrimination and other protective laws** that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies.

- Does the country have an anti-discrimination law? Does it protect people living with HIV and key populations from discrimination?
- Is there a legal age of consent to have sex? Is it in conflict with laws that determine the age of consent to HIV testing, access to information about SRH and contraception and other services and commodities for adolescents? Does it discriminate against girls and women?

- Are there traditional and customary laws and practices that discriminate against people living with HIV and key populations?
- Are there legal remedies available to people living with HIV and key populations when they experience discrimination on the grounds of HIV status and/or their membership of a particular group?
- Are there specific laws that protect people living with HIV from discrimination in employment, including prohibiting employment related HIV testing and confidentiality of medical information? Are there laws that prohibit discrimination against people who test positive for HIV?
- Are there laws that prohibit people from living with HIV from travelling to your country?
- Are people living with HIV and key populations able to seek redress, including by accessing legal aid, should their rights be violated?

Women and girls

Guidelines 8: States, in collaboration with and through the community, should **promote a supportive and enabling environment for women, children and other vulnerable groups** by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

- Are there laws or policies that discriminate against women, including in respect of marriage, divorce and child custody, access to employment and economic opportunity and inheritance and ownership of property?
- Are there laws or policies that prevent or inhibit women and girls from obtaining independent access to sexual and reproductive health care?

Access to reproductive and sexual health care

Guideline 5 states laws should not discriminate against women and girls in their access to SRHR.
This includes:

- Access to reproductive and STI health infor¬mation and services;
- Access to their chosen means of contraception, including safe and legal abortion, the right to determine number and spacing of chil¬dren, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape; and
- The age of consent to sex and marriage should be consistent for women and men and the right of women and girls to refuse marriage and sexual relations should be protected by law.

- Are there laws or policies that prohibit or undermine the provision of CSE to adolescent girls and boys including parental consent requirements?
- Are there laws that require informed consent from adolescents for medical procedures that are not consistent with their ability to understand and consent to the procedure?
- Are there laws that prohibit compulsory HIV and pregnancy testing of adolescents?
- Are there laws or policies that prohibit girls from returning to school if they are pregnant or have given birth?
- Are there laws that set a minimum marriage age at 18? If so, is the age the same for boys and girls?
- Are there laws that protect women and girls from harmful practices?
- Are there laws that criminalise domestic violence against women and girls, including marital rape?
- Is sex trafficking and all other forms of exploitation criminalsed?
- Are women and girls able to seek redress, including by accessing legal aid, should their rights be violated?

Key populations

- Is sex work or elements of sex work criminalised in your country?
- Is adult consensual same-sex sex criminalised in your country?
- Are drug use or possession of drug paraphernalia criminalised in your country?
- Are there laws or policies that promote access to HIV prevention, treatment, care and support for sex workers and their clients?
- Are there laws or policies that promote access to SRH and HIV prevention, treatment, care and support services for gay men and other men who have sex with men?
- Are there laws or policies that promote access to HIV prevention, treatment, care and support for transgender people?
- Are there laws or policies that promote access to HIV prevention, treatment, care and support for sex workers?
- Are there laws or policies that promote access to HIV prevention, treatment, care and support for people who use drugs?
- Does the legal definition of rape and sexual assault include rape of men and boys?
- Are there laws or policies that mandate the provision of post-rape treatment and care, including emergency contraception and PEP, to prisoners?
- Are there laws or policies that undermine the provision of tailored and CSE to transgender and LGBTI youth?
- Are key populations able to seek redress, including by accessing legal aid, should their rights be violated?

How to organise an inclusive parliamentary hearing on HIV and SRHR

Parliamentarians often have the power to organise public hearings to gather information from experts, hold discussions with various stakeholders, both inside and outside government and hear directly from members of the public and those most affected by an issue. These hearings provide opportunities for parliamentarians to strengthen their own capacity to fulfil their roles more effectively.

Parliamentarians can organise hearings on any aspect of HIV and SRHR they are concerned about.

Possible topics for parliamentary hearings on HIV and SRHR

- Access to CSE for adolescents: is it available in all schools? Does it promote gender equality and sexual and reproductive health and rights?
- What are the key barriers to HIV testing and treatment?
- Linking HIV and SRH services? Is it working? Have HIV and SRH services been integrated for adolescents? For pregnant women and new mothers? For key populations? For women living with HIV? For men?
- GBV against women and key populations.
- Harmful cultural, religious and other practices, including child marriage, property grabbing, female genital mutilation and widow inheritance.
- Key populations and access to HIV prevention, treatment, care and support.
- Access to abortion – the impact of criminalisation on women's health.
- Criminalisation of HIV transmission, exposure and/or non-disclosure: what are the benefits and/or harms?

Convening hearings and events on HIV and SRHR will inevitably involve dealing with controversial and sensitive subjects. Hearings should be carefully planned to ensure that those affected by the issues are able to participate meaningfully in the discussions and that everyone who participates is treated with dignity and respect.

Parliamentarians organising public hearings should consider the following principles:

1. Full participation of people living with HIV

It is important to make sure that the voices and experiences of people living with HIV are actively included in all hearings and events about HIV. Without their perspectives, parliamentarians will miss out on crucial information and lose the opportunity to hear directly from those most affected by the HIV epidemic.

Parliamentary hearings give people living with HIV a rare opportunity to share information and their personal experiences directly with policy makers - as they are often deeply stigmatised and marginalised in public debates about HIV, they rarely have access to parliamentarians or the ability to influence policies and programmes about HIV and SRHR.

Parliamentary hearings are also critical opportunities to fight stigma and discrimination and recognise the important role that people living with HIV can play in combatting the epidemic and advancing universal access to prevention, treatment, care and support.

Dos and don'ts:

Do:

- Involve organisations led by and working on behalf of people living with HIV in the design and planning of the hearing;
- Include people living openly with HIV in the hearings, where possible;
- Ensure that people living with HIV participating in the hearings are properly briefed about the procedures and their role – given their exclusion from policy making, people living with HIV may need support and training to enable them to participate meaningfully in the hearing;
- Pay specific attention to ensuring a diverse range of people living with HIV can participate in the hearing; and
- Provide translation services, where needed.

There are a diverse range of issues facing people living with HIV and a single person living with HIV or organisation can never fully represent all these issues. When designing a public hearing, it is important for parliamentarians to be sensitive to questions about representation. Parliamentarians should work closely with a diverse range of groups to better understand the realities they face and what barriers they may face to participating in the hearing.

Don't:

- Disclose anyone's HIV status without first getting their permission to do so; and
- Use stigmatising or degrading language or innuendos.

2. Gender dynamics

Gender inequality and GBV prevents women, including women living with HIV or women from key populations, from participating meaningfully in many aspects of public life. Women living with HIV are particularly excluded which means that the unique issues facing them are often invisible to policy makers.

Parliamentary hearings present an important space for policy makers to actively seek and engage with women living with HIV and to ensure that their views and needs are properly represented in the hearing.

Dos and don'ts:

Do:

- Get to know and involve organisations led by women living with HIV e.g. support groups, in the design and planning of the hearing;
- Be aware that women living with HIV may not be connected to sources of information about parliament and public hearings and so, special outreach might be required to ensure they know about the hearings;
- Ensure that women participating in the hearings are properly briefed about the procedures and their role – given their exclusion from policy making, they may need support and training to enable them to participate meaningfully in the hearing;
- Be aware of cultural and traditional gender roles that may undermine women's ability to participate in public meetings;
- Be aware of gendered issues, such as child care, that prevent women from participating in public life and take steps to remove these barriers; and
- Ensure that women who participate in public hearings are treated respectfully and their views and the information they provide are treated equally to those provided by male participants.

Don't:

- Organise hearings at night or other times that might prevent women from participating;
- Organise hearings in remote areas which cannot be accessed by most;
- Disclose anyone's HIV status without first getting their permission to do so; and
- Use stigmatising or degrading language or innuendos.

3. Key populations

People from key populations may be hesitant or even afraid to participate in a public event such as a parliamentary hearing, especially if their sexual orientation, gender identity, employment or behaviour is criminalised. They may also face other barriers to participation, including: homophobia, social isolation, stigma, lack of social recognition of their gender identity, sexual orientation or employment as well as poverty and feeling uncomfortable in a parliamentary setting.

Dos and don’ts:

Do:

- Get to know and involve organisations led by and working on behalf of key populations in the design and planning of the hearing;
- Be aware that key populations may not be connected to sources of information about parliament and public hearings and so special outreach might be required to ensure they know about the hearings;
- Ensure that people from key populations participating in the hearings are properly briefed about the procedures and their role – given their exclusion from policy making, they may need support and training to enable them to participate meaningfully in the hearing;
- Be aware of the power imbalance between parliamentarians and people from key populations and how it can affect their participation;
- Protect their confidentiality, especially where participation in a public event could expose them to criminal prosecution. If needed, allow for people from key populations to meet privately with parliamentarians; and
- Provide translation services, where needed.

Don’t:

- Organise hearings at night or other times that might prevent key populations from participating;
- Use stigmatising or degrading language; and
- Disclose that someone is a member of a key population without their permission.

tool 2

Sample parliamentary questions

Parliamentarians can ask parliamentary questions and ministers are obliged to answer and provide information about their work and the work of their departments. Parliamentary questions can be an important tool to hold government accountable to parliament.

Parliamentarians can use parliamentary questions to get information about HIV and SRHR:

Sample questions

Abortion

- Does the government have information about the costs of unsafe abortion for the public health system?
- Does the government plan to decriminalise abortion?
- Where abortion is legal under certain circumstances, what is government doing to address the barriers to safe abortions and increase awareness of the circumstances under which women may access legal abortions?
- Does the ministry of health/department of health provide access to post-abortion care? What steps has the ministry of health/department of health taken to ensure that women are aware that they can legally access post-abortion care?
- Has the government endorsed the African Commission on Human and People's Rights campaign to decriminalise abortion?

Adolescent girls and young women:

- Is the department of education providing CSE at schools? Does this include information about HIV prevention and accessing contraception?
- Are efforts made to ensure that out of school youth have access to CSE?
- Are there laws and/or policies that require parental consent for adolescents to access HIV and sexual and reproductive health services? Are the ministries/departments of health and justice planning to amend these laws to ensure that adolescents can exercise their SRHR?
- Is there a policy preventing girls from remaining in or returning to school once they are pregnant or have given birth?
- Is there a national strategy to combat sexual violence against girls in schools?

Cervical cancer

- Is there a national strategy on cervical cancer screening, diagnosis and treatment?
- Is the HPV vaccine available to all adolescent girls?
- Is the government collecting data on the number of adolescent girls who have received the vaccine?
- Is the government collecting data on how women living with HIV are affected by cervical cancer?

Child marriage

- If child marriage is legal or customary, what is government doing to reform laws and cultural practices that allow child marriage?
- Is there a national strategy to eradicate child marriage?
- Has the government endorsed the African Union Campaign against child marriage?
- Has the department of justice undertaken a review of laws regarding children to ensure that the protect children from child marriage?
- Has the government undertaken an assessment of the links between child marriage and HIV?

Contraception and family planning

- Where the age of consent for contraception is different from the age of consent to sex, what is the government doing to reform laws to address the inconsistency?
- Has the ministry/department of health put in place policies that support the family planning needs of women living with HIV? If so, do these policies promote access to information, services and commodities that are appropriate for the needs of women living with HIV?
- Has the ministry/department of health trained health care workers to counsel and support the family planning needs of women living with HIV, including their right to become pregnant?
- Has the ministry/department of health trained health care workers to counsel and support the family planning needs of girls and adolescent women?

Key populations

- Is the government collecting data on whether people from key populations are accessing HIV prevention and treatment?
- Does the government have a national prevention strategy for key populations?
- Does the government have a national strategy to address violence against key populations?
- Has the government assessed the impact of criminalising sex work/same sex sexual conduct/drug use on rights violations against these groups and access to HIV and SRH services?
- Has the ministry/department of health trained health care workers to provide HIV and sexual and reproductive health care to people from key populations?
- How much of the HIV programming needs of key populations is government carrying and is government prepared to take over 100% of this cost in due time?
- Prevention
- Does the ministry/department of health have a national condom and lubricant distribution strategy?

- If there is a national condom distribution strategy, does it identify priority populations? Does it include national targets?
- Has the ministry/department of health done a review of the impact of laws that criminalise HIV transmission, exposure or non-disclosure on prevention efforts?
- Is the ministry/department of health providing appropriate information on HIV prevention to key populations and young people?
- Does the ministry/department of health have a national prevention strategy for key populations?
- Does the ministry/department of health have programmes in place to reduce multiple concurrent sexual partnerships?
- Does the ministry/department of health have an alcohol prevention strategy for adolescents and young women and men?

Stigma and discrimination

- Has the ministry department of health trained health care workers on HIV-related stigma and discrimination and stigma and discrimination against key populations?
- Does the ministry/department of health have an accessible complaints system for patients who have been discriminated against?
- Is there an intention to create an independent body to deal with issues relating to discrimination on the basis of sexual orientation, drug use or sex work employment status?
- What is the government doing to ensure access to justice for key populations?
- Has the government undertaken or supported a Stigma Index review?

Treatment

- What are the costs of treatment?
- Are there trade or patent laws that inhibit access to affordable medicines?
- Is the government using TRIPS flexibilities to advance access to affordable medicines?
- What are the main sources of funding for ART? How much funding comes from international donors and how much from the national health budget? Is government prepared financially to take over the total cost of treatment
- Is the budget for ART disaggregated to collect data on key populations accessing ART?
- Does the ministry/department of health provide access to routine viral load testing?

Joint parliamentary committee on HIV and SRHR

Parliamentary committees, in various forms, are a feature of all SADC national parliaments. These committees, made up of members of all political parties elected to the national assembly, provide space for smaller groups of parliamentarians to work together to carry out in-depth work and better inform the work of their parliaments on these issues.

Benefits of parliamentary committees

- Increasing the amount of work that can be done: it is more efficient for a large group to delegate its work to smaller groups than to try to do it all in a single group;
- Ensuring that issues can be debated in more depth than can be done in plenary sessions (because more time is available to concentrate on details and the committee is dedicated to that particular theme);
- Increasing the participation of all parliamentarians in discussions (members of a group can participate more fully when the group is small);
- Enabling parliamentarians to develop expertise and in-depth knowledge of the committee's area of work;
- Providing a forum for the public to present its views directly to parliamentarians, something which is not possible in a plenary sitting of parliaments[127]; and
- Committees usually report back to the parliament sitting in plenary and the recommendations of a committee have more weight than a motion of one parliamentarian.

Over the past two decades, many SADC national parliaments have established committees that focus on HIV and the SADC-PF has consistently advocated for national parliaments to set up parliamentary committees on HIV to ensure an adequate focus on the epidemic by parliaments.

These committees take different forms: some parliaments have dedicated HIV committees, others rely on the parliamentary committee on health to include a specific focus on HIV. In addition, other parliamentary committees such as social welfare and education may also identify HIV as a priority and examine the implications of HIV for their sector.

Few, if any SADC parliaments have parliamentary committees dedicated to SRHR. Issues relating to SRHR tend to be dealt with by parliamentary committees on health, gender and HIV. It is possible that the increasing focus on SRHR in SADC may galvanise parliaments to consider establishing SRHR committees.

Role of a joint committee on HIV and SRHR

There are clear practical benefits to establishing parliamentary committees with mandates to focus on both HIV and SRHR that can act as focal points for HIV and SRHR in parliament. Setting up such a committee would also be of great symbolic value, signalling the importance that parliaments attach to these issues and their integration. Parliamentarians who are members of an HIV and SRHR committee can develop important and ongoing relationships

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[127] *Ideas, Parliament, Politics and AIDS, a comparative study of five African countries, 2006, http://www.parlcent.org/en/wp-content/uploads/2011/04/handbooks_and_guides/Parliaments_Politics_and_HIV_Study_2006_EN.pdf*

with key experts on HIV and SRHR, CSOs working on HIV and SRHR and individuals who are most affected by the issues. Participation in the committee can greatly enhance parliament's oversight role.

A parliamentary committee on HIV and SRHR could:

- Monitor and oversee the work of various government departments working on HIV and SRHR in a more holistic manner;
- Organise public hearings on SRHR and HIV;
- Ensure that proposed laws address the links between HIV and SRHR and that all laws support and promote a rights-based approach to HIV and SRH; and
- Scrutinise international and regional human rights instruments and monitor reporting on the progress of domesticating and implementation of these standards to ensure that governments are meeting their obligations.

Checklist of factors to consider when setting up an HIV and SRHR committee

The success and effectiveness of an HIV and SRHR committee will depend on a number of factors and parliamentarians should consider the following questions before setting up a committee:

Does a parliamentary committee on HIV already exist?

If parliament already has a committee on HIV, it is important to ascertain whether that committee would be willing to incorporate a focus on SRHR. It is advisable to strengthen an existing committee rather than constituting a new one.

Does the committee have a clear mandate?

Prior to beginning any work, the committee should develop a clear mandate and terms of reference to guide its work. Members of the committee should familiarise themselves with important concepts including a rights-based approach to HIV and SRH. The committee's mandate will differ from country to country, depending on the context but it should include a focus on integration, legislation and budget oversight. A good way to ensure support for and consistency in the work of the committee is to amend the standing orders or rules of operation of parliament to include the committee and its terms of reference.

What are the roles and responsibilities of the committee?

The committee should develop working methods that allow it to develop good relationships with other institutions responsible for SRHR and HIV. There may already be other parliamentary committees that have identified SRHR and/or HIV as a priority, for example, a committee working on gender equality - this committee should develop a clear sense of where it adds value and support to this work, rather than duplicating it.

[128] *Adapted from: The Role of Parliamentary Committees on HIV/AIDS, http://www.parliamentarystrengthening.org/HIVmodule/pdf/unit8.pdf*

What is the size of the committee?

The size of the committee can influence the quality of its work and its ability to function successfully. A committee that is too large or too small is likely to be ineffective.

Who will be the chair of the committee?

The chair of the committee should be considered carefully as it can play a critical role in its success: she or he will have to manage the activities of the committee and mediate when there is conflict between members. While this is an important function for any committee chair, it is particularly vital when the committee deals with controversial and complex issues relating to SRHR and HIV. Attention should be paid to gender parity in leadership and in the composition of the committee.

What resources are available to the committee to assist it in its work?

Ideally, the committee should be able to employ staff that support its work. Attention should be paid to employing staff with relevant expertise and to gender parity.

General references and resources

International human rights instruments

International Covenant on Civil and Political Rights (ICCPR)
http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx

International Covenant on Economic Cultural and Social Rights (ICESCR)
http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
http://www.ohchr.org/EN/HRBodies/CEDAW/Pages/CEDAWIndex.aspx

Convention on the Rights of the Child (CRC)
http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

Convention on the Rights of Persons with Disabilities
https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, OHCHR and UNAIDS
http://data.unaids.org/publications/irc-pub07/jc1252-internguidelines_en.pdf

Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030
http://www.hlm2016aids.unaids.org/wp-content/uploads/2016/06/2016-political-declaration-HIV-AIDS_en.pdf

Where to check if your country has ratified a treaty: **http://indicators.ohchr.org/**

Regional human rights instruments

African Charter on Human and People's Rights
http://www.achpr.org/instruments/achpr/

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa
http://www.achpr.org/instruments/women-protocol/

The African Charter on the Rights and Welfare of the Child
https://www.au.int/web/en/treaties/african-charter-rights-and-welfare-child

SADC laws and policies

SADC Protocol on Gender and Development
http://www.sadc.int/files/8713/5292/8364/Protocol_on_Gender_and_Development_2008.pdf
SADC PF Model Law on Eradicating Child Marriage and Protecting Children in Marriage
http://www.sadcpf.org/index.php?option=com_docman&Itemid=149

SADC PF Model Law on HIV
http://www.sadcpf.org/index.php?option=com_docman&Itemid=149

Resources for parliamentarians

Parliament, Politics and AIDS, a comparative study of five African countries, 2006, Ideas
http://www.parlcent.org/en/wp-content/uploads/2011/04/handbooks_and_guides/Parliaments_Politics_and_HIV_Study_2006_EN.pdf

Parliaments and the Sustainable Development Goals, IPU and UNDP
http://www.ipu.org/pdf/publications/sdg-toolkit-e.pdf

Brief for Parliamentarians on HIV and AIDS, Making the law work for the response to HIV, IPU, UNAIDS and UNDP
http://www.ipu.org/pdf/publications/aids12-e.pdf

Handbook for Parliamentarians, Taking Action Against HIV, 2007, UNAIDS
http://data.unaids.org/pub/manual/2007/20071128_ipu_handbook_en.pdf

Raising the profile of HIV/AIDS in your parliament, IPU
http://www.ipu.org/PDF/publications/hiv-aids-guide-e.pdf

Fast-Tracking HIV Treatment: parliamentary actions and policy options, 2015, IPU and UNAIDS,
http://www.unaids.org/sites/default/files/media_asset/2015_IPU_HIVtreatment_en.pdf

The Global Goals, also known as the Sustainable Development Goals (SDGs)
http://www.globalgoals.org/

Women and girls

Report of the High- Level Working Group on the Health and Human Rights of Women, Children and Adolescents, Leading the Realisation of Human Rights to and through Health, 2017
http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportHLWG-humanrights-health.pdf

What works for Women and Girls – Evidence for HIV Interventions
http://www.whatworksforwomen.org/

UNAIDS landing page on women and girls – this website provides resources on women and girls and HIV
https://womenandgirlsandaids.unaids.org/

Harmonising the Legal Environment for Adolescent Sexual and Reproductive Health and Rights, a review of 23 countries in East and Southern Africa, 2017, UNFPA
http://www.up.ac.za/media/shared/1/ZP_Files/unfpa-esaro-laws-and-policy-review-on-asrhr-2017.zp119762.pdf

HIV and human rights

ARASA HIV, TB and Human Rights in Southern and East Africa Report, 2016
http://www.arasa.info/files/3314/8119/1044/ARASA_2016_Human_Rights_report.pdf

Office of the High Commissioner of Human Rights, landing page on HIV/AIDS and Human Rights
http://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx

Country progress reports – **UNAIDS**

UNAIDS guidance note, Fast-Track and Human Rights, Advancing human rights in efforts to accelerate the response to HIV, 2017
http://www.unaids.org/sites/default/files/media_asset/JC2895_Fast-Track%20and%20human%20rights_Print.pdf

The law, HIV and TB pertaining to children and young people
http://arasa.info/files/5215/0833/3522/ISSUE_BRIEF_01_The_Law_HIV_and_TB_pertaining_to_children_and_young_people.pdf

Stigma and discrimination, legal frameworks and access to justice
http://arasa.info/files/9315/0833/3749/ISSUE_BRIEF_02_Stigma_and_Discrimination_Legal_Frameworks_and_Access_to_Justice.pdf

Women, HIV, TB and the law
http://arasa.info/files/4815/0833/3753/ISSUE_BRIEF_04_Women_TB_HIV_and_the_Law.pdf

Criminalisation of HIV, TB and key and vulnerable populations
http://arasa.info/files/5415/0833/3759/ISSUE_BRIEF_05_Criminalisation_of_HIVTB_and_Key_and_Vulnerable_Populations.pdf

Access to essential medicines and diagnostics
http://arasa.info/files/3415/0833/3756/ISSUE_BRIEF_03_Access_to_Essential_Medicines_and_Diagnostics.pdf

Key populations

Identifying Injustice: Law and Policy on Sexual Orientation, Gender Identity and HIV in Southern Africa
http://www.arasa.info/files/5214/6728/7474/Identifying_Injustice-_Law_and_Policy_on_Sexual_Orientation_Gender_Identity_and_HIV_in_Southern_Africa.pdf

ARASA Sexual Orientation, Gender Identity, HIV and Human Rights Advocacy Toolkit
http://arasa.info/files/8414/3860/4501/ARASA_Toolkit_full_web.pdf

International and regional HIV and SRHR commemorative days

International Women’s Day	8 March
International Sex Workers Rights Day	10 March
International Day Against Homophobia and Transphobia	17 May
World Contraception Day	26 September
Global Day of Action for Access to Safe and Legal Abortion	28 September
International Day of the Girl Child	11 October
Transgender Remembrance Day	20 November
16 Days of Activism to End Violence against Women	25 November – 10 December
World AIDS Day	1 December
International Human Rights Day	10 December

SADC
Parliamentary Forum
Forum Parlementaire
Fórum Parlamentar

ARASA
AIDS & Rights
Alliance
for Southern Africa