FRONTLINE AIDS

IMPROVING THE AGENCY AND EQUITY OF MARGINALISED COMMUNITIES IN THE COVID-19 CRISIS

ADVOCACY BRIEF FOR ORGANISATIONS WORKING ACROSS THE HUMANITARIAN-DEVELOPMENT NEXUS

ABOUT THE ACCESS PROGRAMME

The ACCESS programme is an IPPF-led consortium comprised of Frontline AIDS, Internews, the London School of Hygiene and Tropical Medicine, The Open University, and the Women's Refugee Commission. It aims to leverage the consortium's expertise to design and test innovative solutions that enable the most marginalised and underserved people to access comprehensive, evidence-based sexual and reproductive health and rights.[1]

ACKNOWLEDGEMENTS

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ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

As a result, 1.5 million people were infected with HIV in 2020 and 690,000 died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

ABOUT THE WOMEN'S REFUGEE COMMISSION

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Young people gather for a condom demonstration and SRHR talk in Kampala, Uganda.

ACCESS CONSORTIUM
Approaches in complex & challenging environments for sustainable SRHR

WOMEN'S REFUGEE COMMISSION

FRONTLINE AIDS

[1] Further information here: https://frontlineaids.org/frontline-aids-joins-new-consortium-promoting-sexual-and-reproductive-health-and-rights/

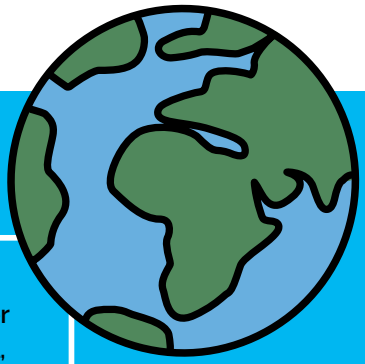
1 INTRODUCTION

BACKGROUND

This advocacy brief is based on a study conducted in 2021 under the Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health and Rights (SRHR) (ACCESS) programme. It explores the equity and relative agency of selected marginalised communities in Lebanon, Mozambique, and Uganda, with consideration for the impact of the COVID-19 pandemic 2020-2021. Data were gathered through a literature review and 20 qualitative interviews with representatives of several marginalised communities, including sex workers, transgender people, men who have sex with men, lesbian, bisexual, queer and intersex (LGBT+) people, people living with HIV, people living with a disability, and adolescent girls and young women. These groups were selected for the study as a priority for the ACCESS consortium because they are most vulnerable to HIV and sexual and reproductive health (SRH) risks, and because of the difficulties they face accessing services and support due to their marginalised status.

The following is a summary of the key findings, and recommendations for humanitarian and development actors on how to better address the barriers to marginalised people realising their power, equity and agency, and challenges across the humanitarian-development nexus.

2 KEY FINDINGS

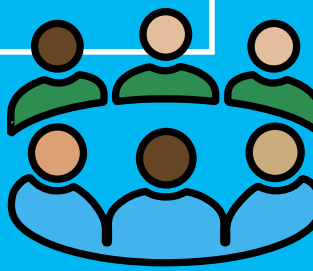


KEY MESSAGES

1 In Lebanon, Uganda and Mozambique, the marginalised communities of sex workers, transgender people, men who have sex with men, lesbian, bisexual, queer and intersex (LGBT+) people, people living with HIV, people living with a disability, and adolescent girls and young women face multiple barriers around their SRHR and related services, including HIV treatment, care, and prevention. Often the result of stigma, discrimination and criminalisation, these barriers are different to those experienced by other communities and require different responses. These difficulties have been exacerbated by the COVID-19 pandemic.

2 It is vital for the humanitarian sector to acknowledge and be unafraid to support communities who might be seen as 'politically difficult' due to their criminalised or stigmatised status. Barriers to realising agency and equity for these marginalised communities are often rooted in the political and addressing political and structural factors is vital to meet their needs. Barriers can be universal (affecting all marginalised communities) or context-specific, depending on national and local attitudes, levels of criminalisation, and attitudes of the health, social and law enforcement sectors.

3 Adopting an approach drawing on interventions from both the humanitarian and development sectors is likely to be beneficial in stable times (using preparedness), in times of crisis (using crisis response and support), and in recovery (for longer-term planning). The development and humanitarian sectors have much to learn from one another and agreeing on shared outcomes is likely to increase the health, well-being and rights of marginalised populations.



1 **People living with HIV:** living with HIV is not criminalised or illegal in Lebanon, Uganda, or Mozambique, which means that people are more likely to advocate for their rights and seek better structural support. As one of the oldest and strongest movements, this group also attracts more attention and funding. However, social stigma is still present, especially if a person living with HIV is also a sex worker or part of another marginalised group. This results in double stigma, and increased risk of harassment or arrest by the police.

2 **Sex workers:** face sexual harassment and risk of arrest across all three countries, though this is perhaps more muted in Mozambique. Strong advocacy networks do have clear benefit, but social acceptance of sex workers in all countries is limited, and they are often not explicitly included in government-led interventions to relieve poverty.

3 **People who use drugs:** experience significant stigma, especially towards women. Drug use is illegal in all three countries and community members experience regular police brutality. Harm reduction programmes are underdeveloped or based on a limited understanding of key issues by some stakeholders, for example in Mozambique. But there are signs of progress, such as in Uganda where a groundswell of coordinated advocacy is amplifying the voice of people who use drugs to seek less punitive national policies. However, barriers to equity remain in all three countries.

4 **Adolescent girls and young women:** initiatives to promote SRHR for this group are evident in Lebanon, Uganda and Mozambique, though cultural and social norms – particularly dominant patriarchy – are a major stumbling block. Women are generally seen as second-class citizens, limiting their power, and sustaining their vulnerability to gender-based violence with no legal recourse.

5 **People with a disability:** there are supportive policies, but clear gaps in implementation of them in all three countries. Disability-friendly infrastructure and communication channels are underdeveloped, limiting the capacity to advocate for better services.

6 **Men who have sex with men:** face entrenched negative attitudes across all three countries. Heteronormative societies routinely move to deny the rights and limit the freedom of this group. Robust advocacy initiatives do have some impact, however, though these are often to provide effective community support (horizontal) rather than national-level policy changes (vertical). That said, raising the profile and amplifying the voices of men who have sex with men is active; in Lebanon through social media, and elsewhere through the creation of drop-in centres to coalesce the community and provide a platform for targeted advocacy.

7 **Transgender people:** experience perhaps the most egregious negative attitudes of all the LGBT+ communities. Support organisations are not always well informed and, particularly for transgender people and lesbians with more masculine gender expression, there is often limited understanding and awareness of their specific needs. The situation appears most difficult in Uganda and Lebanon; Mozambique has had success in advocating for uptake of WHO guidelines for transgender people and training the police in supporting all marginalised communities. However, advocacy initiatives are often included within the broad scope of LGBT+ programmes, therefore missing the subtleties required to support them effectively, e.g., access to hormone treatment.

8 **LGBT+ people:** face different lived realities, and lesbians with masculine gender expression, transgender people, and men who have sex with men with more feminine gender expression experience the most difficulties. In contrast, lesbians with gender expressions conforming to traditional feminine norms, bisexuals, and other gay men report fewer negative experiences due to being able to hide their identity and avoid stigma. Of the three countries, based on the data, perhaps Mozambique has the most progressive approach, allowing LGBT+ people some influence at national-level technical working groups. In contrast, in Uganda and Lebanon there are restrictions on opportunities for influencing policy, because of punitive legislation or general lack of acceptance of these marginalised populations.

Participants in a Frontline AIDS HIV prevention programme for LGBT+ people in Mozambique.

Interwoven throughout the findings are enablers and barriers to the agency and equity of marginalised communities:

ENABLERS

- Strong civil society organisations (CSOs) and networks can offer local support mechanisms, such as drop-in centres, that are more supportive of access to SRHR services where national guidelines are established, such as in Uganda. They also enable voices to be heard at the national level to influence policy.
- Representatives of HIV key populations employed at health facilities to provide education and awareness about the needs of these communities and to support them.
- Creative approaches to raising the profile of marginalised groups to capitalise on modern modes of communication, e.g., social media in Lebanon.
- Where enforcers of legislation (e.g., the police) are provided with sufficient knowledge and skills to engage with marginalised communities, e.g., in Mozambique.

BARRIERS

- Negative social attitudes, especially towards those with whom it is easy to identify as 'different'. This is exacerbated in time of crisis, for example sex workers seen in Uganda as vectors of COVID-19 infection, increasing stigma and harassment.
- Punitive legislation or insufficient decriminalisation can easily be used to harass or incarcerate marginalised communities.
- Lack of understanding and experience of health care providers, some CSOs and support networks (such as limited knowledge about people who use drugs noted in Mozambique).
- The cumulative impact of intersecting forms of marginalisation – where, for example, a sex worker may also belong to another marginalised group (e.g., living with HIV, or being transgender) – compounds levels of stigma, discrimination, and criminalisation, and makes it even more difficult to meet needs.

3 RECOMMENDATIONS

HUMANITARIAN NGOS AND MULTILATERAL AGENCIES

- **Be conscious of the criminalised status of different communities** in each context, and how stigma and discrimination cause people to fall out of social support systems, excluding them from government-led interventions. This requires targeted but sensitive support (i.e., in locations where communities are concentrated, going through community-led organisations, and not labelling services which could disclose their identity to others).
- **Be cognisant of how intersecting identities** create specific and multiple forms of marginalisation, resulting in exclusion from support (e.g., disabled transgender sex workers), and make space in needs assessments for the interaction of different needs which augment vulnerability, rather than address needs in isolation.
- **Work across the humanitarian and development nexus** in preparedness, response, and recovery, balancing the needs of the many with the needs of the most vulnerable. Working with and through community-led organisations is one of the most effective ways to address this, as they have already established networks and trust among communities at risk.
- **Engage and work with development and community-led organisations** to learn about: 1) effective preparedness structures for HIV treatment distribution and working with marginalised communities, which might be replicated into other areas of crisis response including SRHR; and 2) how community-led organisations have integrated crisis responses during COVID-19 into their ongoing work as part of working adaptively and responding to community short- and longer-term needs.
- **Work with international development and community organisations** to establish strong coordination inclusive of marginalised populations, across all sectors and stakeholders. This will enable better understanding of each sector's priorities, achieve greater coherence, and improve preparedness and resilience outcomes for marginalised communities. Humanitarian actors should focus on recovery and transition to local authorities as early as feasible.
- **Agree together on collective short-, medium- and long-term outcomes.** In protracted situations, this can be effective in addressing immediate needs whilst creating a roadmap for development goals, and does not need to jeopardise humanitarian principles. Select a point of entry, such as in emergency preparedness and recovery, led by communities, and work with civil society organisations, and governments to build local and national resilience, improve response, and facilitate efficient and effective recovery.

INTERNATIONAL DEVELOPMENT ORGANISATIONS

- **Work with humanitarian actors and organisations** to target fragile and conflict-affected areas in a more operational manner and share learning on effective strategies to ensure that interventions are responsive to the needs of each marginalised community.
- **Focus on tackling stigma through community awareness,** as this is the one of the most pervasive and continuing barriers for all marginalised communities in all contexts and is exacerbated for people with multiple, intersecting marginalised identities.
- **Support community-led organisations working with LGBT+ people** as a priority. People whose gender expression does not conform to normative gender roles are particularly at risk of stigma, discrimination, and additional barriers to accessing services and their rights.
- **Engage with community-led organisations of marginalised populations** to identify unique capacities and needs in each context as vital to maximising the effectiveness of both short- and long-term interventions, including community capacity strengthening with strategies to counteract structural factors restricting agency.

NATIONAL CIVIL SOCIETY ORGANISATIONS

- **Support the coordination and connection** of community-led and community-based organisations (CBOs) to leverage advocacy for less well-represented marginalised communities (e.g., transgender people, people with a disability).
- **Work with community-led organisations** where they want support with channelling community voices to influence national level policy. Many CBOs are under-resourced to focus on advocacy at this level and might benefit from national CSOs with connections to national policy-makers and organising.

COMMUNITY-BASED ORGANISATIONS

- **Ensure staff are from the communities** being served to avoid additional barriers and discrimination experienced by individuals when accessing services.
- **Connect with other organisations/networks** serving similar or different marginalised communities for strength of voice and inclusion in crisis response, preparedness, and longer-term support.
- **Consider whether engaging in national advocacy** could secure longer-term or structural changes to benefit the target community/ies.
- **Learn from communities** who are coordinating their advocacy for effective impact e.g., networks of people who use drugs in Uganda, and what factors might be replicable.
- **Consider different modes of communication** to reach communities, including closed social media spaces (e.g., Facebook groups, Discord), apps (e.g., Grindr) and encrypted messaging platforms (e.g., Viber, WhatsApp).
- **For CBOs working with multiple communities, recognise the varying and specific needs of individuals within communities,** especially for people with overlapping vulnerabilities and provide space for each community to articulate its needs.
- **Build in preparedness for crises.** Good practice includes a crisis modifier – a strategy to enable early action and rapid response to new humanitarian needs – when designing any project, such as finance-based forecasting. This increases community preparedness and the likelihood that funds are readily available to address a crisis or shock when it happens.

GOVERNMENT MINISTRIES

- **Include marginalised communities** in government social support packages, without repercussion if their identities or behaviours are criminalised, especially in response to crises such as COVID-19. This means recognising sex work as being eligible for income support, recognising individuals not part of a family unit as eligible for support (e.g., LGBT+ people) or people without ID or health insurance cards (e.g., transgender people).
- **Channel support through local community-led organisations** to reach the most marginalised. CBOs have the experience and trust of communities and can reach individuals who wouldn't want to use government-led services.
- **Prioritise implementing policies** for disabled people's rights where these are in place.
- **Train police and other law enforcers** with the knowledge and skills to engage with marginalised communities in respectful and non-violent ways, particularly with sex workers, transgender and other LGBT+ people, and people who use drugs.
- **Train health care staff** with tailored knowledge on the individual needs of, and skills to provide stigma- and discrimination-free care to, people from every marginalised community, including those with multiple identities, e.g., people who use drugs living with HIV.

DONORS

- **Be guided by communities** around what they choose to prioritise in their strategy setting. Their voices and experience provide the strongest insights into what is required.
- **Invest in innovative approaches that address gender inequality** and that amplify the community response to increase community power. Equity requires differential approaches to correcting inequality, and a one-size fits all approach is unlikely to be suitable in many situations.
- **Provide resources for advocacy** to less represented communities, in particular for people with a disability, transgender people and less represented members of the LGBT+ community, who have fewer funding streams available to them, less access to resources and few or no organised networks at national level to advocate for their rights. A political voice is one of the few recourses that remain for people who are criminalised, invisible to social support structures, and targeted by state actors.
- **Provide resources for capacity strengthening** of marginalised communities to better organise and advocate for their rights and the implementation of supportive existing policies. Strong civil society organisations and networks can offer better local support mechanisms and advocate at national levels.
- **Commit resources to emergency response funds** which support the multiple needs of marginalised communities, beyond legal aid or health services alone. There are times when clothes, shelter, food, and counselling may also be needed at the same time.
- **Prioritise support for transgender communities,** who remain the most stigmatised, and most excluded from collective advocacy campaigns, government support and humanitarian responses. Resource organisations that focus specifically on their rights (i.e., are transgender-led) and that understand the subtleties of barriers facing transgender communities and to which they can best respond.

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