5 PILLARS FOR HIV PREVENTION

Issue Brief 2

The Missing Piece of the Puzzle

RIGHTS+EQUITY+JUSTICE for HIV PREVENTION

Combination prevention programmes for all key populations

Key populations are communities and groups that include sex workers; gay men and other men who have sex with men; transgender people; people who inject drugs and prisoners. Key populations experience both increased impact of HIV, and decreased access to services.

Combination prevention programmes are rights-based, evidence-informed, and community-owned. They combine biomedical, behavioural, and structural interventions. These are prioritised to meet the needs of particular individuals and communities in order to have the greatest impact.

Structural factors[1] fuel the high HIV burden amongst key populations:

STIGMA

DISCRIMINATION

VIOLENCE

CRIMINALISATION

SOCIAL EXCLUSION

The high burden of HIV amongst key populations is not only an issue of ethics and justice, it is also costly to society. More and more evidence is showing how interventions that address these structural barriers can make a significant and cost-effective contribution towards reducing the number of new HIV infections.

This issue brief examines some of the structural barriers to HIV prevention faced by key populations. It also explores some entry points for advocacy to address those barriers.

ARASA AIDS & Rights Alliance for Southern Africa

The HIV epidemic in East and Southern Africa: where are we now?

The 2020 targets

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

- reduce AIDS-related deaths
- reduce new infections

} to less than 500 000[1]

The HLM, for the first time, set specific programme targets for HIV prevention, supported by 5 pillars:

For key populations, the global target set by UNAIDS is:

90%

to be reached with combination HIV prevention.

While reductions in global AIDS-related deaths continue at a pace that puts the 2020 target within reach, the rate of new HIV infections is not falling fast enough to reach the 2020 target of under half a million new infections per year.

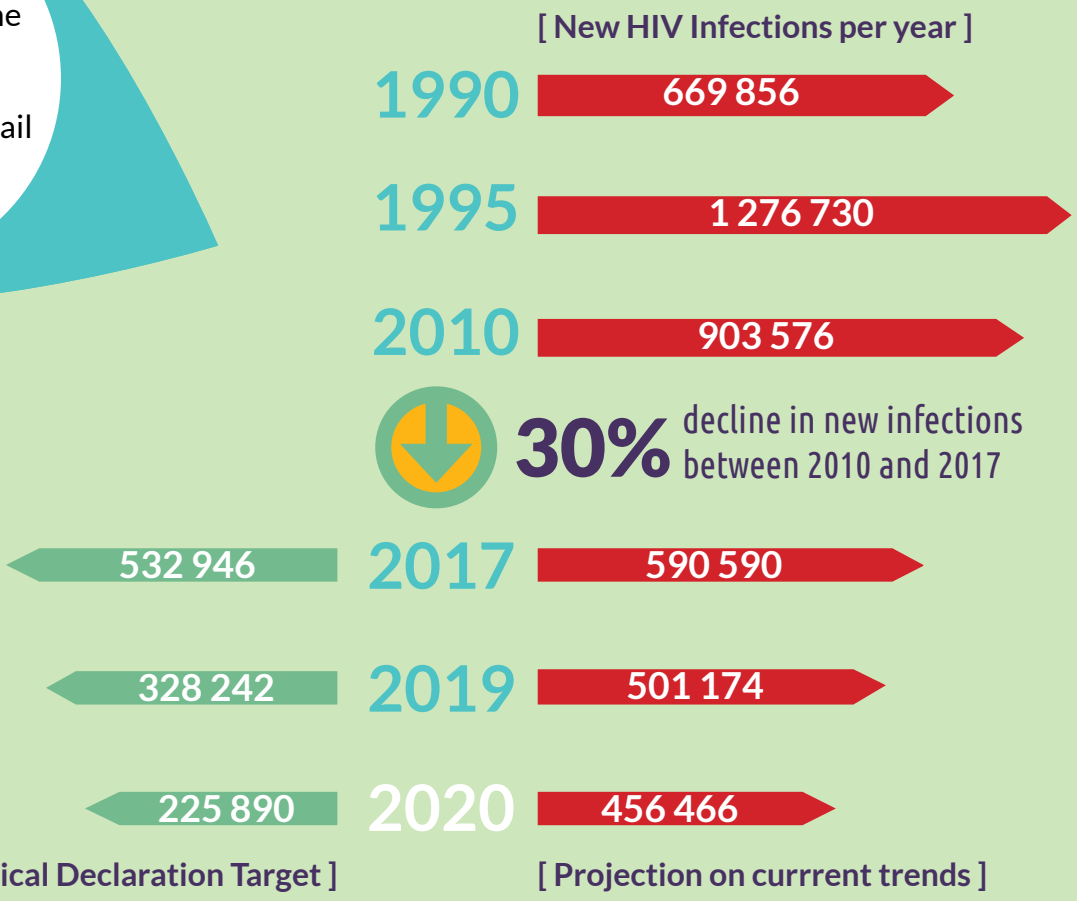
Out of all regions of the world, East and Southern Africa is in fact faring the best, with new HIV infections declining by 30% between 2010 and 2017.

Pillar		Target
adolescent girls and young women (AGYW)	1	reduce new HIV infections among young women and girls to under 100 000
key populations	2	ensure that 90% of people at risk of HIV can access prevention services
condom programming	3	make 20 billion condoms available annually in low and middle-income countries
voluntary medical male circumcision (VMMC)	4	provide 25 million more men with VMMC
pre-exposure prophylaxis (PrEP)[iii]	5	provide PrEP to 3 million people at risk of HIV

In order to reach the global targets, SADC has committed to reduce the amount of new infections by 230 000 per year. This is a 75% reduction from the levels in the SADC region in 2010.

PROGRESS TOWARDS 2020 HIV PREVENTION TARGETS IN SADC

Progress is still too slow, and if the region continues at the current trajectory, it will fail to meet the 2020 targets.[iv]



Treatment as Prevention is not enough

The goal of getting people onto antiretroviral treatment has surpassed everyone's expectations. Treatment has been shown to be an effective means of HIV prevention.

Estimates shows that achieving UN treatment goals alone can only reduce 60% of new infections[iv]. We therefore need a renewed focus on primary prevention[2].

Principles of programme interventions for all 5 pillars

Effective and efficient prevention programmes have the following elements:[v]

- They are comprehensive and integrated
- They are smart: they ask, "What works?", "With which populations?" and "In which settings?"
- They respect and protect human rights
- They are gender-sensitive and/or gender-transformative[3]
- Services are delivered at community level
- They make use of local programme data to for continuous improvement.
- They can be scaled up.

The 5 HIV prevention pillars are components of an integrated response.

Why key populations?

Globally, compared to the general population, gay men and other men who have sex with men (MSM), people who inject drugs, sex workers, and transgender women are far more likely to be living with HIV.

In East and Southern Africa, all key populations have higher rates of HIV compared to the general population.[viviiviiiixx]

28x
gay men and other men who have sex with men

22x
people who inject drugs

13x
sex workers

13x
transgender women

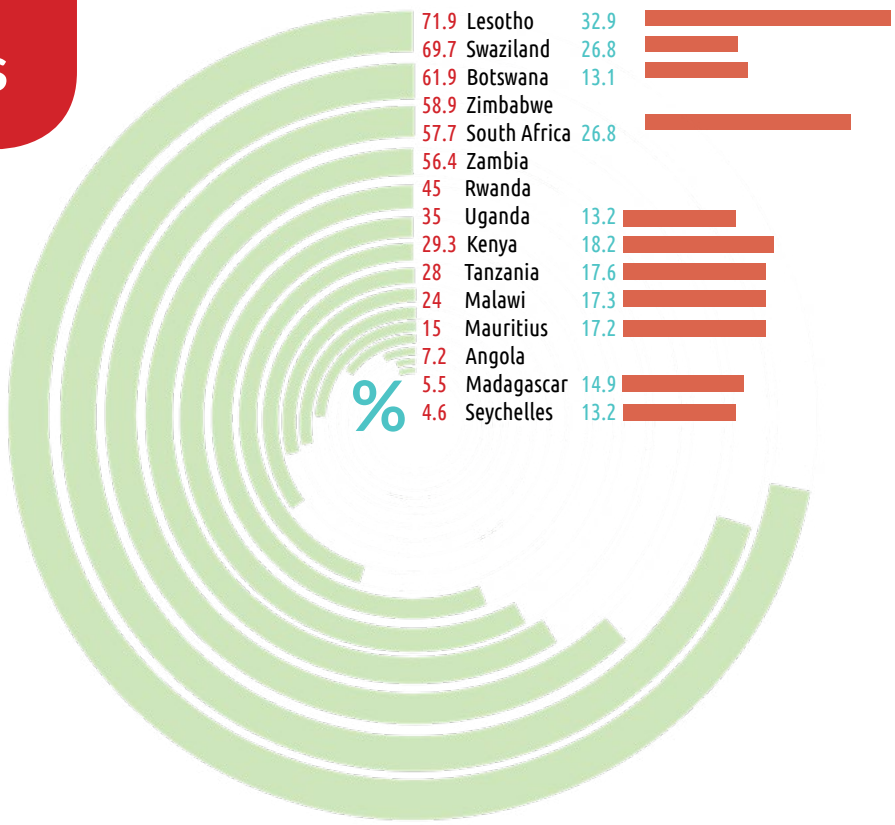
Despite their vulnerability, these are often the groups that are least likely to obtain access to HIV prevention, treatment, and care services.[xi]

Structural Barriers

A range of barriers increase the vulnerability of key populations to HIV infection. They also negatively impact access to HIV prevention, treatment and care.

These barriers include:

- legal and policy barriers;
- stigma and discrimination;
- violence; and
- a lack of - or inadequate - data, investment and programmes to address HIV by governments and donors.



Legal and policy barriers

In Southern and East Africa, key populations often face criminalisation

This includes laws and policies that make sex work, or parts of sex work a criminal office. Similarly, parts or the whole of, same-sex sexual behaviour and drug use can be criminalised.

This is despite the many international and African human rights instruments that have been ratified by countries and specifically call on governments to reduce or eliminate such laws and policies.[xiii4]

Criminalisation is one of the greatest structural drivers of HIV infections for key populations.

It enables and strengthens other drivers such as stigma and discrimination, violence, and a general lack of services.

The removal of punitive laws and policies can potentially have the greatest impact on reducing HIV infections amongst key populations. For example, estimates suggest that decriminalisation of sex work would reduce HIV incidence among sex workers by 33 to 46 percent.[xiv]

However, change is happening. While criminalisation remains the norm across the region, the majority of countries have recognised key populations in their national HIV plans and strategies to fight HIV and STIs including the need to improve legal and human rights protections for key populations.[xv]

Summary of law or policy barriers for key population programmes

Criminalisation of transgender people	Criminalisation of aspects of sex work	Countries	Criminalisation of same-sex sexual behaviour	Criminalisation of drug use or possession	Laws or policies prohibiting condoms in prisons
🟨	🟩	Angola	🟩	🟥	🟥
🟨	🟥	Botswana	🟥*	🟥	🟥
🟨	🟥	DRC	🟨	🟥	⬜
🟨	🟥	Eswatini	🟥	🟥	⬜
🟨	🟩	Lesotho	🟥	🟥	🟩
🟨[1]	🟩	Madagascar	🟨	🟥	⬜
🟨	🟥	Malawi	🟥	🟥	🟥
🟨[1]	🟥	Mauritius	🟥*	🟥	⬜
🟨	🟨	Mozambique	🟨*	🟥	⬜
🟨[1]	🟥	Namibia	🟥	🟥	🟥
🟨[1]	🟥	Seychelles	🟨*	🟥	⬜
🟩	🟥	South Africa	🟩	🟥	🟩
🟥	🟥	Tanzania	🟥	🟥	🟥
🟨	🟥	Zambia	🟥	🟥	🟥
🟥	🟥	Zimbabwe	🟥	🟥	🟥

🟥 Criminalised and/or prosecuted 🟨 Neither criminalised nor prosecuted 🟩 Change of sex characteristics allowed	🟥 Any criminalisation or punitive legislation 🟨 Dealt with at sub-national level 🟩 Not subject to punitive legislation	[1]These countries allow for change of gender markers in national registries.	🟥 Criminalised 🟨 Neither criminalised nor protected 🟩 Protected	🟥 Drug use or possession is criminalised 🟨 Possession is a criminal offense	🟥 Legal or policy barrier 🟩 No barriers ⬜ No data

*These countries include'sexual orientation' as a prohibited ground of discrimination under labour law.

Stigma and discrimination

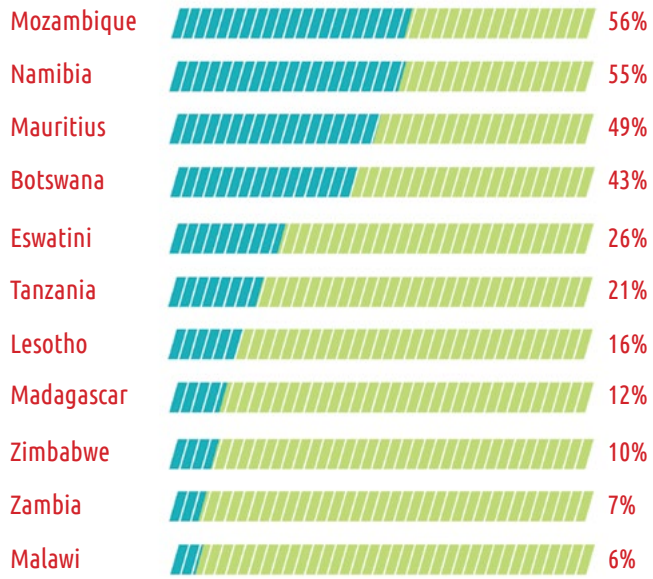
Key populations experience high rates of stigma and discrimination in their communities and in many institutions, including in health care facilities.

"That is the front page of my most recent file. He [the doctor] wasn't supposed to write stuff about my sexual orientation because he knew very well that the file was going to be checked out by everyone including student nurses." - Gay man, Zambia[xvi]

In Botswana, Mozambique, Namibia, South Africa, and Zimbabwe, more than a third of sex workers felt discriminated against when they tried to access a health service.[xvii] Sex workers were also refused medical assistance when health care workers found that they do sex work. These moralistic and judgmental attitudes mean that many sex workers are reluctant to seek assistance in health care settings. Those that do seek assistance prefer to keep their sex work a secret.

"Sex workers accept violence and rape, but it has long-term effects on their lives – they don't seek help when it happens… you find they have defaulted [on ART] and when you go back you discover they were raped when young or while working and they have low self-esteem." - Sex worker organisation member, Queenstown, South Africa

The graphic below shows the proportions of people across 11 countries in eastern and Southern Africa who said they would tolerate 'homosexual neighbours'.



Source: Dulani, Sambo & Dionne[xviii] (2016)

Experiences of stigma, discrimination and violence in the external environment drive high levels of self-stigma.[5] Self-stigma not only increases risk of acquiring HIV, but also negatively affects health seeking behaviour.[xix]

In all countries in the SADC region, individual drug possession and use is criminalised and highly stigmatised.

People who use drugs face discrimination and violence on many levels.[xx]

People who inject drugs acknowledged as a key population:

Comoros	Mauritius	South Africa
DRC	Mozambique	Swaziland
Lesotho	Namibia	Tanzania
Madagascar	Seychelles	Zambia

Provide needle and syringe programmes and/or opioid substitution therapy:

Mauritius Mozambique Seychelles South Africa Tanzania

"People who inject drugs only go to hospital when they are at death's door, or are found unconscious." - peer educator, Tshwane, South Africa[xxii]

In South Africa, many people who use drugs are also homeless, and thus they face double stigma in health facilities. People who use drugs described how nurses make a show of moving away, or opening windows, or waving their hands in front of their noses. Then, once they discover that the person injects drugs they "recoil in horror", They say things like: "You are doing this to yourself," "Come back when you are clean," and "Why should we waste taxpayers' money to help you?" This blatant stigma and discrimination create a strong aversion to using public health facilities.[xxi]

Violence

Incidents of physical and sexual violence and abuse against key populations are disturbingly high.[xxiv]

It is almost universally the case that when key populations experience different forms of violence, including sexual violence, they are reluctant to seek justice. This reluctance is because they are unwilling to 'out' themselves as key populations in their communities. Key populations often assume that the police would not help them anyway because police offers tend to share the stigmatising attitudes of the rest of the community.

The situation is worse when key population activities are criminalised. In these contexts, the police are often perpetrators of violence. For example, research has now shown decisively that sex workers experience significantly more violence in countries where sex work, activities associated with sex work, are criminalised. [xxv]

Criminalisation of key population behaviours creates an environment of impunity, in which violence against key populations is legitimised.

"I went to the police station to lay charges. They just made a fool of me and said that they would not make a case. 'How can a man be raped by another man?... And you want to be female, so the guy was good to rape you.' They just start laughing at me: 'You know that sodomy is not allowed in this country, we cannot take your case. You're also a sex worker, so just go out, go out'. And I was just walking out, what can I do? I was powerless." - Transgender sex worker, Windhoek, Namibia[xxiii]

"Mostly in society being an addict deprives you of having the opportunity of being a normal human being, and no rights are available to [addicts]. In August 2016, I was assaulted by taxi drivers, 'cause security claimed I stole or took walkie talkies from them. I never took anything from no-one. Security confronted me and insisted that it was me, then they took me to the taxi rank where the taxi drivers took further action. They beat the hell out of me for almost two hours. After beating me they decided to burn me inside a dustbin…After having a meeting on how they were going to kill me, I got a chance to escape. Otherwise I would be dead for something I didn't do." - Person who injects drugs, Tshwane, South Africa[xxvi]

In this context of pervasive violence, key populations come to view violence towards them as inevitable, and even normal. As a result they often elect not to access health, social or legal services after experiencing violence; this includes post-exposure prophylaxis (PEP) which could prevent HIV after rape.

Data gaps, lack of appropriate services, and lack of investment

While programmes to prevent HIV amongst key populations are increasing in sub-Saharan Africa, they are still not of sufficient scale and quality to make the necessary impact. Some of the barriers include the following:

While strategic information on key populations is improving in the region year on year, many countries still do not collect and report all the required data. There have also been several cases of key population studies being embargoed if the findings are politically unpalatable.

None of the countries in the region have sufficient national coverage of a comprehensive package of services for all the populations to make an impact on their national epidemics.[xxvii]

Although civil society in many countries is highly committed to provide services that use proven approaches, these services haven't been scaled up because of inadequate political commitment and funding.

Funding for HIV in East and Southern Africa is still highly dependent on international donors, with very little domestic funding. Over 95% of donor funding for HIV comes from only two donors: PEPFAR and the Global Fund. International funding has allowed governments to neglect politically unpopular programmes such as key populations.[xxviii]

Addressing Structural Barriers: progress and change

1. Removing policy and legal barriers

Various efforts are being made across the region to shift the legal and policy environment to become more enabling for work with key populations. Firstly, Legal Environmental Assessments (LEA's) - baseline assessments on laws and policies limiting access to HIV services for key populations – have been conducted in several countries, all of which recommend the removal of punitive laws against key populations. As a rule, however, the recommendations of the LEA's have not been implemented by governments.

Secondly, recent strategic litigation has yielded a series of important wins. In Botswana two landmark judgements by the High Court in 2017 fundamentally altered the landscape for sexual minorities. Previously, the government had refused to register LEGABIBO, an organisation working with LGBTI people, since it would promote the criminal act of 'sodomy'. However, the High Court ruled that constitutional protections extend to the right to freedom of association, amongst others:

"Members of the gay, lesbian and transgender community…form part of the rich diversity of any nation and are fully entitled in Botswana, as in any other progressive state, to the constitutional protection of their dignity."[xxix]

The Ministry of Home Affairs in Botswana also refused a transgender man to change his gender marker[6] from female to male. The case was taken to the High Court in 2017 , where the court overturned the decision of the Ministry, ruling that:

"…the State has a duty to uphold the fundamental human rights of every person and to promote tolerance, acceptance and diversity within our constitutional democracy. This includes taking all necessary legislative, administrative and other measures to ensure that procedures exist whereby all State-issued identity documents which indicate a person's gender/sex reflect the person's self-defined gender identity."[xxx]

2. Leveraging political commitments

At global, continental and regional level, governments have made political commitments to uphold and advance human rights and health.

Civil society have to ensure that they are kept accountable, and can use them in their advocacy. A few of the many examples of these commitments include:

- Many countries in East and Southern Africa are members of the Global Prevention Coalition (GPC). Members of the GPC are obliged to report to UNAIDS on their progress in accelerating HIV prevention.
- SADC Ministries of Health report annually on their progress in HIV prevention. This includes progress in reaching the 90% target for key populations.
- The Universal Periodic Review (UPR) process of the United Nations Human Rights Council includes opportunities for input from civil society.
- The African Union Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030, includes targets which explicitly address the health and human rights of key populations.

For example, one objective states: "Governments should accelerate efforts to address all forms of violence, stigma, discrimination, social exclusion and ensure access to services for key populations and vulnerable groups."

3. Community empowerment and mobilisation:

"Nothing about us without us!"

Community empowerment is at the centre of an effective HIV response. Key population members are experts on their own lives. Collectives and organisations that are community-led are best placed to articulate their challenges and needs. They can advocate for recognition of their human rights, as well as improved services, in a way that others cannot: with strong roots in their experience and knowledge. Stigma and discrimination flourish where there is ignorance. Vocal, visible and assertive key populations reduce can educate politicians, governments, health care workers, and wider society.

4. Addressing stigma and discrimination

Work to reduce stigma and discrimination against key populations is taking place in a number of different ways. Much of this work is led by key population civil society organisations and their allies. Some examples of interventions include:

- use of the media to shift social norms regarding key populations;
- dialogues and other meetings or events convened in local communities between representatives of key populations and local stakeholders;
- raising the profile of key population concerns through a growing number of events and campaigns; and
- engagement to train and sensitise health care workers and other health care facility staff.

5. Addressing violence

Key population-led organisations have trained and deployed paralegals in communities to be 'first responders'.

- These first responders can address issues of violence and abuse in their communities, and encourage more reporting and accountability. The reports are then used as tools to create awareness of the reality that key populations endure.
- Various ways of engaging with police to reduce violence have been tried. These range from collaborative partnerships with the police,[xxxi] informal local engagement,[xxxii] to formal training and sensitisation of police officers.

6. Advocacy for adequate and sustainable investment

Beyond the fundamental human rights and ethical considerations, programmes which improve the health and human rights of key populations are value-for-money interventions.[xxxiii]

Policy changes which create an enabling environment are highly cost-effective, and investments in community and health systems strengthening programmes are investments for sustainability.

Resources

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2. 'The SWIT': Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. WHO; UNFPA; UNAIDS; NSWP; World Bank; UNDP 2013
   Available at: https://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
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5. 'The IDUIT': Implementing comprehensive HIV and HCV programmes with people who inject drugs: Practical Guidance for collaborative interventions. UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAID, PEPFAR. 2017
6. SADC Regional Strategy for HIV Prevention Treatment and Care and Sexual and Reproductive Health Rights among Key Populations
   The Southern African Development Community (SADC) has endorsed and released a Regional Strategy on HIV Prevention Treatment and Care and Sexual and Reproductive Health and Rights for Key Populations. The strategy is a result of a series of participatory and interactive processes that involved members of key populations, governments, civil society and development partners. It is expected to serve as a guide to SADC Member States in designing and implementing appropriate Sexual and Reproductive Health (SRH) and HIV prevention, treatment and care programmes for key populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels. Available at: https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf

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[v]SADC (2017). Framework for target-setting for HIV prevention in the SADC region

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[xii]SADC (2018) ibid

[xiii]HEARD (2015). Human Rights and the HIV Response: Eastern and Southern Africa Region

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[xv]ARASA (2016)

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[xviii]Dulani B, Sambo G, Dionne KY. (2016) Good neighbours? African express high levels of tolerance for many, but not for all. Afrobarometer Dispatch No. 74. March 2016.

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[xx]UNAIDS (2016) Prevention gap report

[xxi]Global Fund (2018) Programs to Reduce Human Rights-related barriers to Access, Uptake and Retention in HIV and TB Services: Baseline Assessment for South Africa

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[xxiii]AIDSfonds (2018). Sex work & violence in Southern Africa. A participatory research in Botswana, Mozambique, Namibia, South Africa and Zimbabwe. Hands Off! Project

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End Notes

[1]Structural factors are factors in the social, political, economic, legal and cultural environment, which exert an influence on individuals.

[2]Primary prevention means activities which aim to prevent a person becoming infected with HIV. In contrast, secondary prevention is aimed at people who are already infected with HIV, to stop them from transmitting the virus to those who are HIV-negative.

[3]Gender-sensitive programmes recognise and respond to the different needs and constraints of individuals based on their gender and sexuality. These activities significantly improve women's and girls' and/or men's and boys' access to protection, treatment or care; however, in themselves, they do little to change the larger contextual issues that lie at the root of gender inequities. Gender-transformative programmes, on the other hand, actively seek to transform gender roles and create relations that are more gender-equitable.

[4]Relevant instruments include the International Covenant on Civil and Political Rights (ICCPR); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); International Covenant on Economic, Social and Cultural Rights (ICESCR) and African Charter on Human and Peoples Rights (ACHPR or the Banjul Charter)

[5]Self-stigma occurs when people believe and internalise stigmatizing attitudes and beliefs about themselves. Self-stigma leads to what has been called the "Why Try" phenomenon, a sense of futility and hopelessness that occurs when people believe they are unworthy because they apply the stereotypes to themselves

[6]The "male" (M) or "female" (F) on a person's birth certificate, identity document.

About ARASA

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

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ARASA AIDS & Rights Alliance for Southern Africa

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

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

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

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

PITCH Partnership to Inspire, Transform and Connect the HIV response

aidsfonds

FRONTLINE AIDS

Ministry of Foreign Affairs

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