5 PILLARS FOR HIV PREVENTION

Issue Brief

5

The Missing Piece of the Puzzle

RIGHTS+EQUITY+JUSTICE for HIV PREVENTION

Pre-exposure Prophylaxis (PrEP)

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.

The World Health Organisation (WHO) recommends that oral pre-exposure prophylaxis (PrEP) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches.

'People at substantial risk' can include key populations, adolescent girls and young women, and sero-discordant couples. If used consistently and correctly, PrEP can virtually eliminate the risk of acquiring HIV. **Adherence to PrEP is the critical predictor of its effectiveness.** To make PrEP as successful as possible, it has to be seen as part of a repertoire of HIV prevention options.

PrEP is still in its infancy, and a number of barriers still exist to its roll out in East and Southern Africa.

Pre-exposure prophylaxis (PrEP) is an HIV prevention strategy where **HIV-negative individuals take anti-HIV medications before coming into contact** with HIV to reduce their risk of becoming infected.

This issue brief examines those barriers, focusing on the structural barriers, and provides ideas on strategic entry points for advocacy.

ARASA AIDS & Rights Alliance for Southern Africa

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

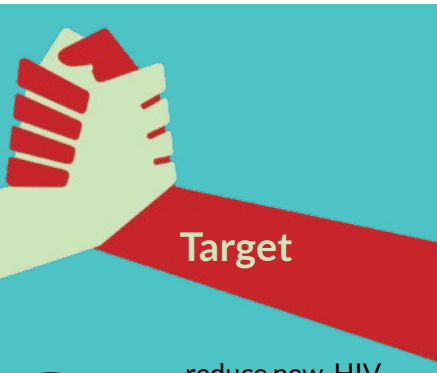
The 2020 targets

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:



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

For PrEP, the global target set by UNAIDS is to provide PrEP to:

3 million
people at high risk of HIV

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.

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.[iii]

[New HIV Infections per year]

1990 — 669 856

1995 — 1 276 730

2010 — 903 576

30% decline in new infections between 2010 and 2017

532 946 — 2017 — 590 590

328 242 — 2019 — 501 174

225 890 — 2020 — 456 466

[Political Declaration Target] [Projection on currrent trends]

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[1].

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[2]
- 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 PrEP?

WHO recommends that oral PrEP containing tenofovir (TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches.[vi]

If used consistently and correctly, PrEP can virtually eliminate the risk of acquiring HIV.[vii]

Adherence to PrEP is the critical predictor of its effectiveness.

To make PrEP as successful as possible, it has to be seen as part of a repertoire of HIV prevention options. In targeting people at substantial HIV risk, PrEP can also be viewed an entry point for accessing a range of services which can contribute to reducing risk, such as:

- male and female condoms and lubricant
- STI, HBV, HCV screening
- re-testing
- partner testing
- vaccination
- family planning
- addressing issues such as gender-based violence and HIV stigma, and education about treatment as prevention (TasP).[3]

Unlike HIV treatment, people do not have to stay on PrEP for life. PrEP is normally taken for periods of weeks, months or a few years when a person feels most at risk of HIV.

Who is "at substantial risk"?

While some groups can be said to be at 'substantial risk' everywhere, other groups may be deemed to be at substantial risk based on where they live, and the epidemiology in those locations.

- Sero-discordant couples everywhere are candidates for PrEP, where PrEP can be used until the HIV+ partner starts treatment and becomes virally suppressed.
- In most places in sub-Saharan Africa, gay men and other men who have sex with men, transgender women, and sex workers are at substantial risk.
- In addition, in some specific locations, such as the KZN province in South Africa, adolescent girls and young women (AGYW) may be at substantial risk.

However, It is important to remember that, among those who are at high risk, not everyone will want PrEP, or be eligible for PrEP.

Structural Barriers to PrEP

A number of structural barriers still exist to the roll out and scale up of PrEP in East and Southern Africa. We look at some of these barriers here:

A learning curve: PrEP is in its infancy. There is still a lot to learn about implementation of PREP in the real world, outside of the research setting. The provision of PrEP is relatively complex when compared with other biomedical HIV prevention tools.[viii] PrEP is still not broadly available in public health facilities.

Regulatory and policy barriers: Many countries are still in the process of addressing the policy and regulatory requirements for them to implement PrEP, such as the development of national PrEP policies, and the registration of TDF for prevention with national medicines regulatory authorities.

Policies which restrict adolescent's access to sexual and reproductive health care will have a negative impact on access to PrEP for AGYW. For example, there may be national policies around the age of consent for HIV testing or for receiving prescription medicines. When health care workers are obliged by law to report minors selling sex to the police and social services, this is a major deterrent to access to health services.

Uptake lower than expected: Demand for PrEP in some ESA countries appears to be lower than anticipated, indicating the need for targeted, appropriate, evidence-informed demand creation activities.[ix]

Adherence concerns: There is evidence that some of the early predictions about the population-level impact of PReP, extrapolated from randomised control trials, may have been overly optimistic. Some PrEP programmes are experiencing high loss to follow up.[x] The lesson is that biomedical solutions can only be successful when they form part of a combination prevention toolkit, provided in an enabling, non-judgemental, person-centred environment.

Key populations: Key populations, one of the high risk groups for whom PrEP is indicated, experience stigma, discrimination and marginalisation, often fuelled by criminalisation, in most countries in East and Southern Africa, which act as a deterrent to their access to, uptake of and retention in both HIV and non-HIV health services.

Adolescent girls and young women: For AGYW, there are multiple barriers at the individual, interpersonal, social and structural levels. Many adolescents lack adequate knowledge or sex in general, and HIV prevention in particular; they fear being scolded or lectured by adults, and thus do not feel free to engage in frank conversations about their sexual and reproductive health with health care workers. Those who are in risky situations, such as those with a history of sexual violence, intimate partner violence or transactional sex, may find it more difficult to disclose to health care workers. Finally, adolescents whose behaviours are criminalised or stigmatised – such as those who engage in transactional sex, men who have sex with men, people who inject drugs and transgender people –may have even greater difficulty in accessing services.

Women experiencing intimate partner violence (IPV): PrEP empowers individuals with limited personal prevention options to discreetly take control of their own HIV risk. One such group is women who experience IPV. Even though PrEP is their most discreet HIV prevention option, experience with, or fear, of IPV can still affect whether women disclose PrEP use to their partners, as well as their ability to adhere to consistent use.

Need for skilled education and support: Individuals who are eligible for PrEP require a considerable amount of skilled counselling, education and support to assist them with assessing their risk, deciding whether PrEP is right for them, and then starting and adhering to PREP.

Cost considerations: PrEP is more expensive than condoms and VMMC; however from a national health finance perspective, taking into consideration how PrEP can prevent serious illness, disability and death, it still cost-effective. However, most individuals are currently receiving PREP through donor funded programmes aimed at key populations or AGYW. Thus, as with the other 4 prevention pillars, sustainability is a concern. In addition, for individuals outside of donor-funded programmes, who would have to foot the bill themselves, cost has been identified as a barrier by prospective PrEP users.[xii]

"When I first heard about PrEP, I thought it was meant for promiscuous people – I did not think it was for me at all. I must say, it wasn't easy in the beginning. Taking a pill when you are not sick is not child's play."

from a blog by a 20-year old student from KZN, South Africa[xi]

Addressing the barriers to VMMC

The barriers outlined above can be addressed, using a range of smart strategies, based a foundation of a human rights and people-centred approach. These include addressing legal, policy and regulatory barriers; and ensuring sensitised, supportive, non-stigmatising care for all PrEP users, including AGYW and key populations. Some key strategies to improve and increase access to PrEP are outlined below:

A human rights and people-centred approach:
It is important to adopt a human rights and people-centred approach when offering PrEP to those at substantial risk of HIV. Similar to other HIV prevention and treatment interventions, a human rights-based approach gives priority to issues concerning health for all, gender equality and health-related rights including accessibility, availability, acceptability and quality of PrEP services. Although the public health rationale underpins the WHO guidance on PrEP, the decision to use PrEP should always be made by the individual concerned.[xiii]

Addressing legal and policy barriers:
Efforts to remove the legal and policy barriers which deter people from accessing PrEP and other HIV should be progressed. PrEP policies should provide clear guidelines for delivery of PrEP products that respect, protect, and fulfill the human rights of all people to HIV prevention services regardless of age, sex, gender identity, gender expression, sexual practices, or marital status.[xiv]

Affordability:
PrEP should be provided for free or at low cost.

Integrated and complementary:
PrEP should be integrated into SRH services currently used by women, adolescents, and other target populations to reduce obstacles to uptake. PrEP should be offered at clinics and drop-in centres providing services for specific target populations, including adolescents, sex workers, MSM, and transgender individuals, because these facilities are often viewed as safe spaces that provide high-quality, non-stigmatising care.[xv]

PrEP should not replace or compete with effective and well-established HIV prevention interventions, such as comprehensive condom programming for sex workers and men who have sex with men and harm reduction for people who inject drugs. Rather, PrEP can be seen as a potential entry point into combination HIV prevention and SRH care.

Non-stigmatising demand creation:
Marketing to create demand for PrEP should aim to minimise any stigma associated with it and the people using them. Local message development is vital to determining the most appropriate content. Members of target audiences should be involved in developing messages and identifying communication channels. [xvi]

Meaningful involvement of communities and beneficiaries:
Target populations and communities should be meaningfully involved in developing PrEP policies, guidelines, and implementation plans, and should be involved in assessing policy and program effectiveness. Communities where PrEP is being rolled out should also be involved. Meaningful participation empowers these groups and increases the likelihood that PrEP programs are effective and truly meet the needs of the target populations.[xvii]

Sensitised health care facilities:
Facilities where PrEP is provided should be safe and welcoming spaces. Healthcare workers must be trained and supported to deliver non-stigmatising, non-judgmental, confidential, gender-sensitive, responsive PrEP services.

Addressing violence:
Providers delivering PrEP should be trained to screen for violence, including intimate partner violence, and provide first-line response; referral networks should be developed to meet the holistic needs of clients who have experienced violence.

Transforming gender norms:
PrEP was conceived to fill the urgent need for a woman-controlled HIV prevention method. However, biomedical technology alone will not alter the underlying gender inequalities that make women and girls vulnerable to HIV. PrEP can contribute to, but not replace, efforts to transform gender norms. [xviii]

References

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[iv]Wilton Park (2017. Building a stronger HIV prevention movement in sub-Saharan Africa. Available at https://www.wiltonpark.org.uk/event/wp1518/
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[xii](Mugo,N., Ngure, K., Kiragu, M., Irungu, E. & Kilonzo, N. (2016). PrEP for Africa: What we have learnt and what is needed to move to program implementation. Curr Opin HIV AIDS. 2016 Jan; 11(1): 80–86. doi: 10.1097/COH.0000000000000224
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[xvi]PrEP implementation pack: South Africa 2016-2017. Available at https://www.prepwatch.org/wp-content/uploads/2017/07/SA_ImplementationPack.pdf
[xvii]ibid
[xviii]ibid

Resources

1. World Health Organisation: Policy Brief: Pre-exposure prophylaxis (PrEP): WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP) Published November 2015
   Available at: http://apps.who.int/iris/bitstream/handle/10665/197906/WHO_HIV_2015.48_eng.pdf?sequence=1

2. WHO is in the process of developing a series of modules for different target audiences to provide guidance on PrEP. These modules which are already completed can be accessed at: https://www.who.int/hiv/pub/prep/prep-implementation-tool/en/

3. HIV Prevention 2020 Road Map: Accelerating HIV Prevention to reduce new infections by 75% . UNAIDS
   Available at http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf

4. Members of the Global Prevention Coalition report on PrEP as part of a prevention scorecard, which is available online. https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/

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

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

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

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

PITCH Partnership to Inspire, Transform and Connect the HIV response

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