

Epidemiology for Activists

Introduction

Civil society and community activists are an essential part of the HIV response, and of the broader struggle for sexual and reproductive health and rights. In the history of the AIDS epidemic, activists have amplified the voices of communities, and demanded access to services for those who are excluded, stigmatised and marginalised.

As activists, we are not - and do not have to be - health professionals or health experts. Yet, in doing our work, we often find ourselves confronted with research and health terminology which may be unfamiliar. There is a need to bridge the gap between the knowledge and experience of activists who work closely with communities and the researchers, policy makers, health professionals and other 'experts' whom we engage with. Activists sometimes face what has been called 'the expertise barrier'. The expertise barrier can also be a political and power barrier: it can be used to exclude communities from spaces where important decisions affecting them are made.



This issue brief bridges the expertise barrier by providing a simple introduction to the field of epidemiology. It breaks down some common epidemiological terms. It aims to help activists to understand the basics of HIV research, and how we can engage with research, and use it for effective evidence-based advocacy. This guide is part of a series of the AIDS & Rights Alliance for Southern Africa's issue briefs to help activists to fully participate in decision-making processes around HIV.

2020

What is Epidemiology?

Epidemiology is the study of the distribution and determinants of diseases, and applying that knowledge to manage diseases.

Or in other words, epidemiology is the study of how often diseases occur in different groups of people and why. It also studies what works to prevent, treat and manage diseases.

The two important terms in the definition of epidemiology are:

distribution

determinants

frequency

How many cases there are of a particular disease, and the percentage of a particular group that has a disease, such as the percentage of women in a country who have cervical cancer.



pattern

With the pattern, we want to know how diseases are distributed in society. So, in the case of HIV, who has HIV? Male, female or transgender? Old or young? Rich or poor? Geographically, where are they? In which continents, countries, provinces, districts, cities and towns? We also want to know how the pattern of a disease changes over time.

The **determinants** are the factors which influence a person's health status. A determinant can be an action, an event, or a characteristic. Epidemiologists investigate:

What?

Why?

How?

Examples of **determinants of health** can include personal and inborn features, behaviour, socioeconomic status, cultural factors, environment, education, nutrition, childhood development, access to health and laws and policies.

Within the broader determinants of health, HIV activists often call attention to the **social determinants of health**. Social determinants are "the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life". The graphic below shows some of the social determinants of health.



Social Determinants

Social determinants are considered as the root causes of health and disease. They can also be called the causes of the causes.¹ These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.²

Many factors in our society - including poverty, powerlessness, gender inequality, physical and sexual abuse, lack of education, homelessness, stigma, addiction, violence, untreated mental health problems, lack of employment opportunities, lack of choice, lack of legal resident status and lack of social support - play a role in HIV infection and the ability of people living with HIV to seek treatment, care and support, and thus can be considered social determinants of HIV.



A disease usually has not one, but several determinants. The determinants which are close to the person are called proximal, or downstream or immediate factors. Those which are quite far away from the person are called distal or upstream factors. Those which are in between the proximal and distal are called intermediate factors.

Social determinants of sexual and reproductive health amongst young key populations in Zambia

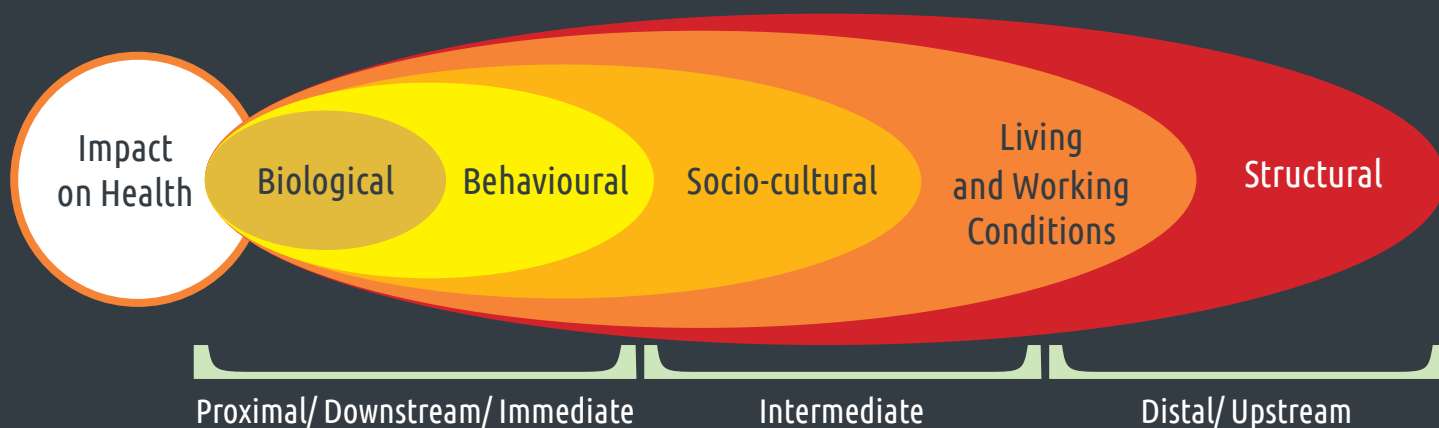
Young key populations - namely young gay men and other men-having-sex-with-men; young sex workers; young transgender people; young people who inject drugs and young prisoners - tend to have poorer sexual and reproductive health outcomes compared to the young people in the general population. Explaining these poorer health outcomes using single determinants like 'not using condoms', or 'sharing injecting needles', does not get to the complex, lived realities of young key populations.

When we explore the social determinants of poor sexual and reproductive health, we can see that young key populations experience multiple forms of inequality, marginalisation and exclusion.

For example, a study on young key populations in Zambia found that they had higher rates of HIV compared to other young people, and that there were multiple intersecting reasons for this. Punitive criminal laws; highly conservative social, sexual and gender norms; the ever-present threat of violence, and public shaming; rejection by families; lack of power within interpersonal relationships; the threat of ridicule and discrimination within health facilities - these are just some of the social determinants.

When we understand the social determinants of health, we start to see that health is also a matter of social justice.

Source: Armstrong, R & Zulu, J (2019). Applying a social determinants of health lens to the situation of young key populations in Zambia: what can it tell us about what we could do? JOGHR, 2019, volume 3.



Determinants of HIV amongst adolescent girls and young women in Southern Africa

Let's use HIV amongst adolescent girls and young women in Southern Africa as an example of how the different levels of determinants work.

Proximal/ Downstream/ Immediate

Biologically, adolescent girls and young women are more susceptible to HIV and other STIs than boys and young men. One reason is because of characteristics of the lining (mucosa) of the vagina.

Behavioural factors which increase risk may be: not using condoms, not knowing one's HIV status, and forced or coerced sex.



Intermediate

Social factors can include: transactional sexual relationships, having more than one sexual relationship at the same time and lack of power to negotiate condom use in relationships.



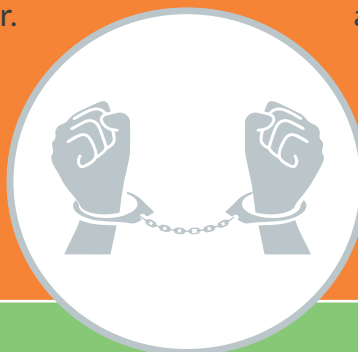
Distal/ Upstream

Living and working conditions which can be determinants include: livelihood and food insecurity, living in a child-headed household, and high rates of sexual violence in the community.

Structural factors can include unequal access to education and employment opportunities, and lack of access to justice for victims of rape.

Structural factors can increase risk of HIV by working on the pathway of determinants. In other words, structural factors have an impact on factors at the intermediate level, such as living and working conditions, or the socio-cultural environment, which in turn can influence the individual's behaviour.

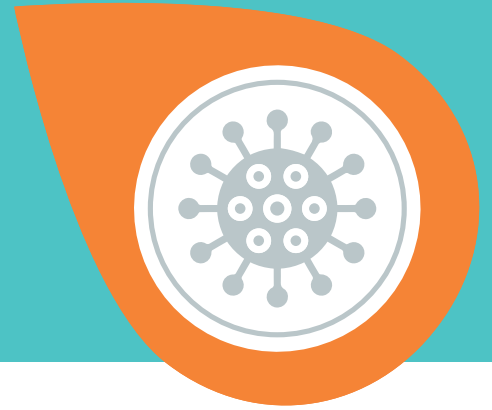
So, for example, criminalisation of homosexuality has been shown to increase risk of HIV in multiple ways. How does it do this? Criminalisation increases



stigma towards LGBT people, which in turn makes them less likely to access HIV prevention, treatment and care services. Criminalisation is also linked to an increase in gender-based and sexual violence, and sexual violence is linked to non-use of condoms. Criminalisation

also increases social marginalisation, which can lead to income and food insecurity, and lack of access to stable housing, which again increases the chance of inconsistent condom use.

Understanding Epidemics



Diseases can be classified differently, according to the numbers of people in a population that suffer from them, and how widespread those diseases are. Let's look at the differences between some of these terms.

endemic

A disease is **endemic** when it occurs in a population or geographic region at a consistent level and over a consistent period of time. For example, in the tropical parts of Africa, malaria is endemic. It may occur only in the rainy season, but it occurs every year. That does not mean that it cannot eventually be eradicated, but diseases which are endemic tend not to be viewed as health emergencies.

hyperendemic

Hyperendemic refers to persistent, high levels of disease well above what is seen in other populations. For example, HIV is hyperendemic in mainland Southern Africa, where as many as one in five adults has the disease,³ and endemic in the United States, where roughly one in 300 is infected.

epidemic

An **epidemic**, on the other hand refers to an increase - often sudden - in the number of cases of a disease above what is normally expected in that population in that area. The term suggests that a disease is out of control.

outbreak

An **outbreak** is similar to an epidemic, but occurs in a more limited geographical area. For example, there have been several outbreaks of the Ebola virus in different countries, mainly in Central and West Africa, since 1976.⁴

pandemic

Pandemic refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.⁵ HIV and TB are both pandemics, in that they occur in every region of the world, with millions of people being infected.

On the 11 March 2020, the World Health Organisation announced that they have characterised the coronavirus, COVID-19, as a pandemic. The WHO's decision is not just a matter of a disease exceeding X number of cases in X number of countries; it is also about acknowledging the massive global impact of the disease, and saying that responding to the disease requires a whole-of-government, whole-of-society approach in order to prevent infections, save lives and minimise impact.⁶

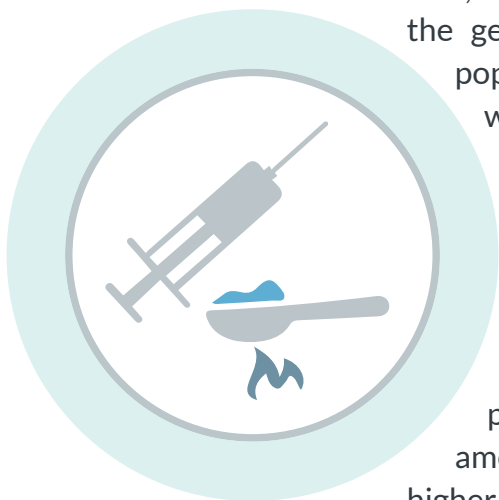


Generalised and concentrated epidemics

HIV epidemics in particular countries can be either **generalised** or **concentrated**. When an epidemic is generalised it occurs widely in the general population. The threshold for a generalised epidemic is more than 1% of the population.

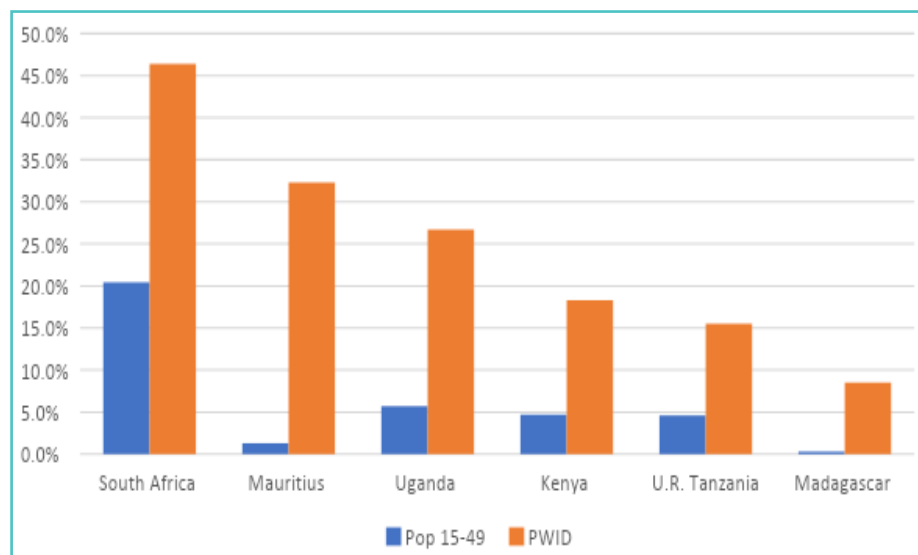
On the other hand, a **concentrated** epidemic has much higher rates – of more than 5% - amongst certain sub-groups within the population.

An epidemic can also be mixed, with features of both. In East and Southern Africa, we have a mixed epidemic: there are rates of HIV above 1% amongst the general population; however, rates are even higher amongst key populations, such as gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners.⁷



For example, look at the graph below. It compares HIV prevalence amongst the general population (people aged 15-49) – the blue bar - with prevalence among people who inject drugs (PWID) – the orange bar - in six countries in East and Southern Africa. You will see that most of the countries have mixed epidemics in that HIV prevalence in the general population exceeds 1%, while prevalence amongst PWID exceeds 5%. In all of the countries, prevalence is much higher amongst PWID than amongst the general population. One country, Madagascar, clearly has a concentrated epidemic, with only 0,3% of the general population infected with HIV, compared to 8,5% of people who inject drugs.

Comparison of HIV prevalence in general population (age 15-49) versus people who inject drugs



Source: UNAIDS Data 2019⁸

Other key concepts in epidemiology



Morbidity

Morbidity means a lack of a state of physical or mental health. In other words, morbidity is used in epidemiology to describe illness, disease or disability. For example, “prisons are associated with increased tuberculosis (TB) morbidity”. Rates of morbidity in a society can be expressed either as prevalence or incidence. These will be explained below.

Mortality

Mortality means the rate of deaths in a population during a certain period. For example, “mortality is higher amongst COVID-19 patients who have co-existing diseases such as high blood pressure, diabetes or HIV”.

Prevalence and incidence

These are terms which are often used, and often confused. In fact, the difference between prevalence and incidence is quite simple.

Prevalence is the percentage of people who are currently infected at a point in time (in a particular population). So for example, if we say, in 2018, Angola had an HIV prevalence of 2% of the population aged 15-49, we mean that 2% of all people aged 15-49 in Angola were living with HIV.⁹

Incidence is the proportion of people who are newly infected during a specific time period (usually a year). Incidence is not always stated as a percentage, sometimes it can be stated as the number per 1000 or 100,000 people, depending on how common or rare new cases are. So in Angola, in 2018, the incidence rate for people of all ages was 1.01 per 1000 people,¹⁰ which means that just over one in every 1000 people became newly infected with HIV in 2018.

Prevalence is affected by two main factors:

incidence

mortality

Incidence and mortality

New infections every year will make the prevalence rate go up. But prevalence is also reduced by mortality (or deaths). In most places in the world, HIV prevalence is going up. This is partly due to more people becoming infected every year, but is also due to the fact that less people are dying than in previous years, due to the scale up of antiretroviral treatment.

Prevalence	Incidence
The percentage of people who are currently infected with a disease.	The proportion of people who become newly infected with a disease during a specific period.

There are different ways of measuring HIV prevalence. The best way is by doing a national population-based survey, such as a Demographic and Health Surveys (DHS). Most governments do these, but usually only every few years. Another common strategy is to routinely test pregnant women in antenatal clinics for HIV. Although pregnant women may not be representative of the entire country, this procedure is convenient and fairly consistent, especially in monitoring trends over time.

Incidence is more difficult to measure: it is difficult to know the exact point when a person became infected. The standard test for HIV measures the presence of antibodies to the virus, and in the early stages of infection, antibodies are not present in large quantities in the bloodstream. There are three different ways of calculating incidence rates: the first is a sophisticated blood test which can tell how recently a person has become infected; the second is to repeatedly test a group of people over time, and note when one of them becomes positive (this is called a cohort study) and the

third is to do surveys amongst similar groups in a particular area over time (e.g. compare the rates of HIV amongst 15 year olds in a district in 2019 with the rates amongst 16 year olds in the same district in 2020. Researchers may not necessarily be testing the same individuals, but they will be testing people who have very similar characteristics, life circumstances and risk profiles).

Measuring HIV prevalence and incidence amongst key populations is a different matter. Ideally, HIV prevalence should be assessed by conducting HIV testing on a sample¹¹ of all members of that key population group. The prevalence rate would then be a percentage, calculated as the number of HIV positive people in the key population group divided by the number of people in that key population in the country.¹² However, because key population behaviours are usually stigmatised and often outlawed, and because key populations are often hidden, getting the data to inform these estimates can be difficult. This is why population size estimates are so critical for key populations.

Integrated bio-behavioural survey (IBBS) studies are important sources of comprehensive information on the status of HIV and STI amongst key populations. These studies use various methods to estimate the size of the population; they also measure HIV and STI prevalence, as well as investigating other information like demographic information and risk behaviours. IBBS studies also tell us what proportion of a key population group has received services, and this is important to inform the design of better programmes.

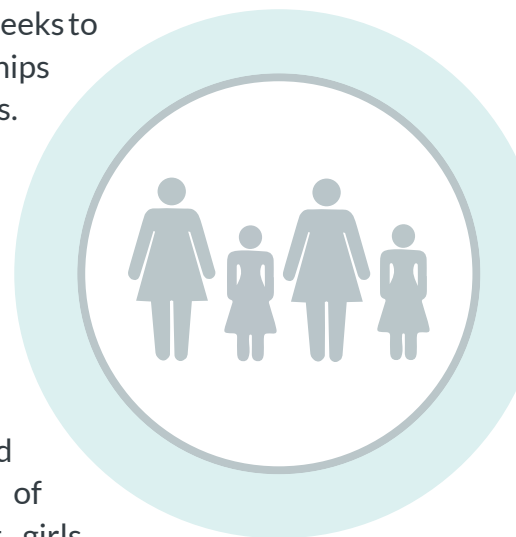
Understanding and using HIV research

Example: Study finds increase in ice cream sales linked to increase in shark attacks!

An epidemiologist is intrigued to discover that the days of the year when more ice cream is sold at a particular beach, are the same days when there are more shark attacks at that beach. Does that mean that ice cream causes shark attacks? No, of course it doesn't. Or does it mean that shark attacks cause people to buy ice cream? Definitely not. The most likely explanation is that on hot days, more people buy ice cream, and more people also go swimming in the sea – hence the increased likelihood of people being attacked by sharks.

In epidemiology, research seeks to understand the relationships between different factors.

Once we have proven that factors A, B or C are determinants of HIV, we can plan programmes to address these. Coming back to the table of the biological, behavioural, social and structural determinants of HIV amongst adolescent girls and young women on page 4, we have evidence that all of the factors in the table increase the risk of HIV. Therefore we should be able to put in place appropriate policies and programmes to address these factors.



Researching relationships between a disease or a condition and possible causes or determinants is challenging and complex. Just because a study shows that two factors (e.g. ice cream sales and shark attacks) have a relationship or a correlation, does not mean that the one factor causes the other to happen. It also doesn't

tell you which direction the relationship is. To use another more realistic example, there is a correlation between HIV and gender-based violence (GBV), but the correlation does not tell us if people acquire HIV because of GBV, or whether being HIV-positive leads to GBV. It is therefore very important to understand that correlation alone does not equal causation.



Are some types of evidence better than others?

In epidemiology, researchers use different types of research to address different types of questions. Some research may be **quantitative** in that it gathers and analyses numbers. Other research may be **qualitative** which describes and analyses information which cannot be measured. Research can also combine both qualitative and quantitative approaches, and is termed **mixed methods** research. Each method has its different strengths and weakness for different purposes.

For example, if a researcher wants to know how effective a treatment or intervention is, **quantitative approach** such as a randomised control trial might be the most appropriate way to test it. Randomised control trials are considered to be very strong forms of evidence, especially in clinical research – because they are relatively good at showing cause and effect compared to other types of studies.

With a randomised control trial, one set of people from a certain population receives a treatment or an intervention (this is the experimental group), while the other group (the control) group does not. The control group might continue receiving the standard intervention, or they may receive a **placebo**.

In medical research a placebo is a treatment that is given to the people in the control group which will have no clinical effect, for example, an injection which contains water, or a pill which does not contain any medicine).

An example of a recent randomised control trial is the HVTN 702 study in South Africa, which tested a new HIV vaccine between 2016 and 2020.

As part of the trial, HIV-negative people at 14 sites across the country agreed to receive six injections over 18 months. Half of those received the vaccine while the other half received a placebo.¹³ People in the both the experimental group and the control group had similar characteristics such as sex, age and geographical location: that way it is easier to know that it is the vaccine that is the cause of the difference in results, and not some other factor (also known as a confounding factor).

Unfortunately, in early 2020, the vaccine trial had to be called off, because when an analysis of the results showed that it was not making a difference at all. People who received the trial vaccine and those who received the placebo did not show any difference in the rates at which they were becoming newly infected with HIV.



If researchers want to find out more in-depth information, such as the reasons for people's behaviour, then **qualitative interviews** might be more appropriate. For example, in order to understand why sex workers in Zimbabwe did not attend clinics for HIV services, one study conducted in-depth discussions with groups of sex workers (focus group discussions), and then analysed the themes that emerged in the discussions.¹⁴

Evidence based advocacy



One of the foundations of HIV advocacy is “know your epidemic, know your response”. Effective advocacy should be based on evidence; many policy-makers, who are the targets of advocacy, demand to see evidence. Evidence-based advocacy uses verified information in order to drive change. Data is gathered, organised, analysed and communicated to produce clear and accessible information which can influence leaders and decision makers.

Quality evidence can produce change

Using good quality evidence for advocacy can make a difference. A recent study – Included! - analysed nine cases where there were important advances in policy or programmes for key populations in east and southern Africa.¹⁵ In most cases, it was quality evidence rather than political rhetoric, that drove change.

As an example, in the late 1990’s, rates of deaths from AIDS were high in Zambia’s prisons. An NGO called In But Free (IBF) collaborated with UNAIDS and UNODC to conduct research into HIV prevalence and risk behaviour amongst men in prison. This research provided critical information on HIV prevalence for advocacy purposes. Because of this the problem of HIV could not be denied by public authorities, and the research catalysed the development of policies and programmes to address HIV in Zambia’s prisons.

The Included! study also found that civil society organisations who understood and used evidence in their advocacy had an enormous advantage. Successful civil society organisations also learnt that policy-makers were more likely to be persuaded by evidence-based public health arguments in conjunction with human rights arguments, and not just human rights arguments alone, especially when it came to issues of criminalisation of key populations.



Harnessing epidemiology for local activism

Women in Khayelitsha, South Africa, reported a huge problem with sexual assaults. At night, in order to relieve themselves, the women would leave their houses and walk long distances to communal toilets. En route, their risk for sexual assault was high.

The women formed a collaboration with an NGO called the Social Justice Coalition and an activist-turned-researchers.¹⁶ By creating a simple mathematical model, the researchers showed that there was a correlation between amount of time spent outside at night walking to the toilet and number of sexual assaults. They demonstrated that if the City of Cape Town installed more toilets, women would spend less time outside, and therefore there would be less sexual assaults.



Sexual assault of women is obviously a human rights issue, but raising economic arguments in addition to the human rights issues can be more persuasive when it comes to advocating with politicians. Thus the researchers used an economic argument to show that, in fact, it would be less costly to install more toilets than it would be to deal with the aftermath of sexual violence.

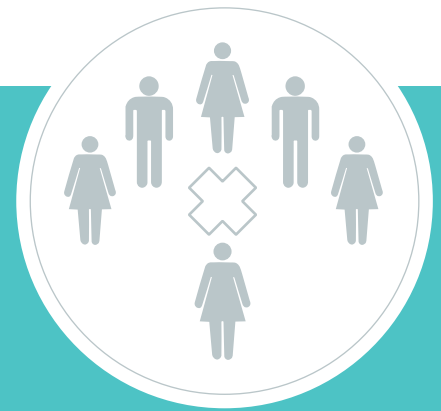
How can civil societies and communities contribute to epidemiology?

So far, we have looked at how we in civil society and communities can understand and use epidemiology. But we can also contribute to epidemiology. Epidemiology has historically tended towards an approach which holds that the scientific method and direct observation are the only sources of knowledge – this is a ‘positivist’ approach. New approaches to epidemiology, such as popular epidemiology and participatory epidemiology – recognise that knowledge is constructed socially, and therefore allows for social or group analysis of life experiences: this is a ‘**constructivist**’ approach.

Constructivist approaches to epidemiology use methods which are participatory, and also are geared towards action to achieve social and structural change.¹⁷ Here are some examples of epidemiological research from East and Southern Africa, in which communities have been meaningfully involved in constructing knowledge.

PLHIV Stigma Index

The PLHIV Stigma Index (Stigma Index) provides evidence on HIV-related stigma and discrimination. Developed by the Global Network of PLHIV (GNP+), the International Community of Women Living with HIV (ICW), the International Planned Parenthood Federation (IPPF), and UNAIDS, the Stigma Index is a research tool by which PLHIV capture data on their experiences of stigma and discrimination. More than 100,000 PLHIV have been interviewed in over 50 languages by over 2000 trained PLHIV interviewers. The Stigma Index has been essential for informing HIV policy, PLHIV rights advocacy efforts, and stigma-reduction interventions.¹⁸



The Hands Off! Programme

The Hands Off! Programme involved sex worker organisations in conducting research into the prevalence and patterns of violence against sex workers in Botswana, Mozambique, Namibia, South Africa and Zimbabwe.¹⁹ The research used a community-based participatory research (CBPR) approach. CBPR is a partnership approach to research, that equitably involves community members, practitioners, and academic researchers in all aspects of the process, enabling all partners to contribute their expertise and share responsibility and ownership. This means that sex workers were actively involved in the design and execution of this research including the design of the research and tools; selection of the hired researchers; data collection and writing the results.



Botshelo ba Trans

Botshelo ba Trans was the first HIV biological and behavioural survey on transgender women in South Africa. The study was a genuine partnership between the Human Sciences Research Council, and community organisations S.H.E, Gender Dynamix, Access Chapter 2 and SWEAT. The methodology explicitly positioned the community of transgender women as knowledge holders in their own right.

Communities were therefore involved in setting the research questions, and planning the study. A lot of time was spent consulting and gaining the trust of the community during each phase of the study, The analysis and write-up of the findings was also collaborative effort.

According to the lead researcher from the HSRC:
“We’ve never worked with communities from the start, [asking them] ‘You tell me what I need to focus on’...It’s a challenge for us because it’s power relations. You know, [assuming] ‘I know best’. And that’s not true. We’re doing this work for the community. So why not engage in an equal way with the community?”²⁰

Knowledge is power

Throughout the course of the AIDS pandemic, activists without formal training in HIV science but facing a life-threatening illness for themselves and their communities, have found it imperative to become experts in HIV epidemiology and research. With this knowledge, they have: formed community advisory boards for clinical trials, helped draft guidelines, and published peer-reviewed articles on HIV.²¹ They have formed collaborations with scientists, and frequently met with pharmaceutical companies and government officials to discuss and propose policies and new research. Their efforts have been vital in getting millions of people access to life-saving treatment.

It is critical that as HIV activists, we continue to arm ourselves with knowledge so we can take our rightful place in decision-making spaces, and ensure that the communities we represent are not left behind.

End Notes

¹<https://www.publichealthnotes.com/social-determinants-health-sdh/>

²https://www.who.int/social_determinants/sdh_definition/en/

³UNAIDS data 2019. Available at: <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

⁴https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/distribution-map.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvhf%2Febola%2Foutbreaks%2F2014-west-africa%2Fdistribution-map.html

⁵<https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html>

⁶<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>

⁷<https://www.who.int/hiv/pub/guidelines/arv2013/intro/keyterms/en/>

⁸UNAIDS data 2019. Available at: <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

⁹<https://www.unaids.org/en/regionscountries/countries/angola>

¹⁰<https://www.unaids.org/en/regionscountries/countries/angola>

¹¹Because it is impractical to test every member of a population, researchers test a 'sample' of that population. The sample is a selection of individuals which is assumed to be representative of the the entire population.

¹²https://www.unaids.org/en/resources/presscentre/featurestories/2017/july/20170710_data

¹³<https://www.health24.com/Medical/HIV-AIDS/News/experimental-hiv-vaccine-trial-stopped-after-jab-found-ineffective-20200203>

¹⁴<https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-698>

¹⁵Ehpsa (2018). EHPsa Case Study Series: Included! How change happened for key populations and HIV prevention. Cracks in the walls: Access to improved services for HIV in Zambian prisons. Available at: <https://www.ehpsa.org/critical-reviews/included>

¹⁶<https://www.nytimes.com/2019/04/08/health/gonsalves-aids-actup-epidemiology.html>

¹⁷Leung, M., Yen, I. & Minkler, M. (2004). Community-based participatory research: a promising approach for increasing epidemiology's relevance in the 21st century. *International Journal of Epidemiology* 2004;33:499–506 Advance Access publication 20 May 2004 DOI: 10.1093/ije/dyh010

¹⁸Friedland BA et al. *Journal of the International AIDS Society* 2018, 21(S5):e25131 <http://onlinelibrary.wiley.com/doi/10.1002/jia2.25131/full> | <https://doi.org/10.1002/jia2.25131>

¹⁹Aidsfonds (2018). Sex Work and violence in Southern Africa – regional report. Available at: <https://aidsfonds.org/resource/sex-work-and-violence-in-southern-africa-regional-report>

²⁰<http://www.hsrc.ac.za/en/review/hsrc-review-sept-2019/transgender-women-network-for-research>

²¹Geffen, N. The role of activists in access to HIV and tuberculosis treatment and prevention. *Curr Opin HIV AIDS*. 2017 Jul;12(4):398–402. doi: 10.1097/COH.0000000000000381.

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.



 **aidsfonds**

FRONTLINE AIDS



Ministry of Foreign Affairs