

'Getting to Zero' in sub-Saharan Africa: Providing HIV services to men who have sex with men

By Louise Bouchier



A young men's dialogue on HIV and AIDS in Swaziland. Individuals in this photo are not necessarily MSM or living with HIV. (Photo by Maserame Mojapele).

Recent years have seen a stabilisation of the HIV epidemics in many sub-Saharan African countries, and in some cases a decline¹. While HIV continues to be a major problem, the goal envisioned by UNAIDS of 'getting to zero' - with zero new infections, zero discrimination and zero AIDS - related deaths may be realisable in the imaginable future

Improvements in national HIV statistics do not show the inequities in HIV vulnerability experienced by different sub-groups within the population. Key affected populations, such as men who have sex with men (MSM), sex workers and their clients, injecting drug users (IDUs) and migrant workers continue to bear a higher HIV burden, even within generalised epidemics. The promising gains at the general population level need also to be transferred to the groups most at risk if we are to achieve an HIV-free generation.

The generalised HIV epidemics of sub-Saharan Africa are primarily driven by heterosexual transmission, and thus, most HIV prevention programmes have focused on heterosexual clients. Cultural and religious factors and norms, stigma and discrimination associated with same-sex sexual relations, and in some countries criminalisation and penalties linked with homosexuality or same-sex practices, have left MSM out of HIV prevention messaging. This low awareness of the specific HIV prevention needs of MSM, combined with hostility and denial, has

contributed to high rates of HIV among this group.

HIV prevalence among MSM in sub-Saharan Africa is estimated at 9-25 per cent.² According to the 2010 UNGASS report, only three out of 52 African countries reported on indicators for MSM.³ MSM constitute an estimated 9.6 per cent of new infections in Kenya and 19.7 per cent in Senegal.^{4,5} The proportion of new HIV infections in sub-Saharan Africa linked to MSM is predicted to rise *ibid*.

Targeted HIV prevention programming

There are both human rights and public health imperatives for improving HIV services and programming for MSM. Firstly, MSM have a right to appropriate health education and health care and to the means to protect themselves. Secondly, HIV epidemics among MSM

are not isolated from the wider epidemics. Bisexual concurrency is common, and as a result, a high rate of HIV among this group has implications for bridging to the wider community.²

HIV prevention needs of MSM are not being met in sub-Saharan Africa. It is estimated that fewer than one in 10 MSM have access to appropriate HIV services.⁵ There are multiple factors that make the provision of targeted programming for these men at best difficult and at worst dangerous. Twenty six out of 52 countries in Africa criminalise sex between men. The illegal status of sex between men may mean that they are targeted for violence, with perpetrators acting with perceived impunity and police unlikely to offer legal recourse.

Additionally, MSM may be afraid to disclose their sexual practices to healthcare workers for fear of arrest and discrimination. Organisations working with MSM are frequently denied government registration because of the criminalised target group. Lack of formal recognition limits access to funding.

Rates of bisexuality are high and many MSM are married to women.^{2,7,8} Bisexual MSM are less likely to identify as homosexual and are harder to reach as they are less likely to engage with MSM-targeted services. In addition, the illegal status of sex between men combined with homophobia in many African settings means that MSM are often a hard-to-reach population for HIV programming.

Other barriers to HIV service provision are a lack of appropriately trained health workers, poor access to condoms and water-based lubricants, limited funding and organisational capacity.

However, despite significant challenges in addressing HIV among MSM, approximately 15 sub-Saharan African countries have targeted HIV prevention programmes for MSM.⁶ Although these programmes are small in scale, they provide important HIV prevention information and materials to this high risk group.

Factors in addressing HIV among MSM

A variety of factors are important for carrying out successful HIV programmes with MSM and for effectively reaching this population. They include:

- Improving health services: Training health workers to provide suitable and respectful care to MSM is essential. Healthcare workers need to be trained in how to ask questions in a non-stigmatising way and to carry out the appropriate tests and examinations to effectively assess and treat MSM. When MSM have access to appropriate VCT services that they feel comfortable using, rates of testing will increase.
- Advocacy: To work effectively within

or to change criminal laws is important. Laws that criminalise homosexuality can be seen to condone violence and discrimination against MSM. Changing criminalising laws is desirable although it is not feasible in many sub-Saharan African countries at present. Where homosexuality is criminalised, advocacy activities can reduce negative police targeting and negative portrayals of MSM in the media. These reductions in negative attention lead to reduced fear among MSM and a great uptake of HIV services.

- Partnerships with other organisations: These are extremely important. A small organisation working with a marginalised population can lack resources and be vulnerable to attack. The most effective organisations working with MSM are doing so through collaboration with others. Effective partnerships are forged between government, other HIV programmes, health care providers and international organisations. A strong network is important for adding legitimacy, protection and for accessing resources.

- Inclusion and participation of MSM: The meaningful participation of MSM in the design, implementation and evaluation of HIV programmes is essential. It is acknowledged that participation of the target group is key to effective and sustainable programming. Community engagement is especially important when working with MSM. Participation is necessary for facilitating access to this hidden population and peer-education and peer-outreach are successful strategies used in many programmes.

Conclusion

MSM have higher HIV rates than the general population, even in generalised epidemics in sub-Saharan Africa, and their needs for HIV services have not been met. In order to realise an HIV-free generation, HIV prevention, testing, treatment and care services must be available to this and other vulnerable populations. In order to ensure the success of programmes targeting MSM, attention should be paid to improving healthcare, conducting advocacy, collaborating with other organisations and engaging these men in programming. Only then will we be able to 'get to zero'.

Lessons learnt

- Low awareness of the specific HIV prevention needs of MSM, hostility and denial, have contributed to high rates of HIV among this group.
- Bisexual MSM are less likely to identify as homosexual and are harder to reach as they are less likely to engage with MSM-targeted services
- Reductions in negative attention lead to reduced fear among MSM and a great uptake of HIV services.

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Getting to zero: Strategic directions for renewed HIV response

It will require a radical reshaping of the global response to significantly reduce new HIV infections. Amid financial constraints, the need to generate greater efficiency is crucial to success and can be achieved if service delivery is approached differently. Success also depends on intensifying what works and focusing efforts where they are most needed.

Revolutionising HIV prevention

Revolutionising HIV prevention politics, policies and practices will shift the debate from HIV prevalence to incidence, enabling identification of transmission hotspots, empowering people, particularly young people, to demand and own the response and create incentives for political leaders to focus on populations and programmes that will make a difference in reducing new infections.

UNAIDS will support the attainment of these goals through generating commitment to prevention throughout society and ensuring that strategic information on epidemics, socioeconomic drivers and responses serves to focus prevention efforts where they will deliver the greatest returns to investment. Other strategies include incorporating new technologies and approaches as they are developed and facilitating mass mobilisation for transforming social norms to empower people to overcome stigma and discrimination and their risk of HIV infection, including through comprehensive sexuality education and the engagement of networks of people living with HIV and other key populations.

Catalysing the next generation of treatment, care and support

This will deliver a radically simplified treatment platform that is good for people living with HIV and will also cut new infections by scaling up treatment access.

Achieving these goals will include catalysing the development of simpler, more affordable and effective treatment regimens and tools; strengthening national and community systems to deliver decentralised and integrated services, such as reducing factors that put people at risk of HIV-related TB and promoting the sexual and reproductive health and rights of people living with HIV; and working with partners to scale up access to tailored care and support for people living with and affected by HIV.

Advancing human rights and gender equality for the HIV response

This means ending HIV-related stigma, discrimination, gender inequality and violence against women and girls—a situation that drives the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services. It also means putting laws, policies and programmes in place to create legal environments that protect people from infection and support access to justice.

Key to these efforts is protecting human rights of people living with HIV, women, young people, men who have sex with men, people who use drugs and sex workers and their clients. Joint effort is required to achieve these goals so that countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses are reduced by half. Similarly, HIV-related restrictions on entry, stay and residence should be eliminated in half of the countries that have such restrictions. At the same time, HIV-specific needs of women and girls should be addressed in at least half of all national HIV responses, and there should be zero tolerance for gender-based violence.■



A Swazi traditional leader who is spearheading HIV and AIDS initiatives. (Photo by Adriaan Backer).

Through this Strategy, UNAIDS will galvanise global commitment to the following actions in support of the outcomes of the 2010 United Nations Summit on the Millennium Development Goals (26):

- Redouble efforts to achieve universal access to HIV prevention, treatment, care and support;
- Significantly intensify efforts to reduce the number of people newly infected;
- Address HIV from a developmental perspective which requires the strengthening of national networks of sound and workable institutions and systems to mount multi-sectoral responses;
- Build new strategic partnerships to strengthen and leverage the linkages between HIV and other health- and development-related initiatives in support of the AIDS plus MDGs agenda;
- Plan for long-term sustainability and accountability through nationally-owned HIV responses.

Source: UNAIDS (<http://www.unaids.org/en/aboutunaids/unaidsstrategygoalsby2015/>)