Aidspan

Independent observer of the Global Fund

African HIV programming failing to respond to acute needs of sexual minorities

Global Fund efforts to target key affected populations including sexual minorities in the fight against HIV may continue to face an uphill battle in sub-Saharan Africa, new studies have shown, because of prevailing stigma and marginalization even within existing programming.

In releasing the series of studies about the HIV burden among men who have sex with men in sub-Saharan Africa, the Journal of the International AIDS Society sought to expose the worrisome trend towards an AIDS epidemic among MSM across the continent, while challenging “the attitudes of complacency and irrelevancy among donors and country governments that are uncomfortable in addressing key populations,” according to an editorial introducing the series.

Current estimates from UNAIDS place HIV prevalence among MSM in sub-Saharan Africa at 17.9%.

Studies conducted in Cameroon, Senegal, South Africa, Swaziland, Kenya and Malawi suggested that the silent epidemic is largely unacknowledged by health policymakers despite exhortations from external funders, including the Global Fund, that targeting this key population is one of the best ways to bring the spread of HIV under control.

A lack of data has been identified as one of the largest barriers to intervention, the studies suggest, with few countries collecting or analyzing the size of the MSM population within their borders.

South Africa, which has one of the largest HIV burdens on the continent, has also generated the largest body of data, beginning with a 1983 study of 250 MSM that revealed a high prevalence of HIV, syphilis and Hepatitis B virus. Another study of rural South African men found that approximately 3.6% of men

studied reported a history of having sex with other men. Among these men, HIV prevalence was 3.6 times higher than among men not reporting male partners.

A study that was conducted in 2008 with a sample of 378 MSM to establish HIV prevalence and associated risk factors among MSM in Soweto found a prevalence rate of 13.2%. Another study conducted in Cape Town in 2010 involving 542 MSM found a prevalence rate of 10.4%. These studies suggest the existence of an epidemic among MSM in the country.

HIV prevalence among MSM has also been quantified in Senegal and Nigeria, while a sero-prevalence study has been conducted among male sex workers in Côte d'Ivoire, where HIV prevalence was measured at 50% among a sample of 96 men in the economic capital, Abidjan.

Another critical barrier identified by the studies – which were also conducted in Cameroon, Kenya, Malawi and Swaziland – was the criminalization of homosexuality in many countries in sub-Saharan Africa: an estimated 38 countries on the continent have made it illegal for any sexual relations to occur between two men or two women.

"Due to the criminalized nature of male-to-male sex in all countries where studies from this issue took place… MSM are often afraid to visit healthcare services; and when they do go, they are reluctant to disclose their sexual histories to healthcare providers for fear of rejection, derision or other negative reactions," the editorial said.

Even South Africa, which has legalized same sex unions and is considered among the more progressive countries in Africa in relation to respect for sexual minorities, a prevailing stigma has prevented outreach, prevention and treatment programmes from being optimally effective. One study identified a correlation between a higher risk of an MSM contracting HIV and his limited knowledge of prevention measures.

Stigmatizing or marginalizing behaviour by healthcare workers was also examined in the compendium of studies published by the Journal. Healthcare workers displayed negative attitudes towards their MSM patients; in one Kenyan study, healthcare workers told the researchers that they were afraid of being perceived by their communities to be MSM themselves when treating MSM patients.

The research concluded that there is not enough specific training provided to healthcare workers in sub-Saharan Africa to respond to the particular needs of MSM and other key populations, which limits their effectiveness in recommending changes to behaviour that can mitigate the risk of HIV transmission. Equally, training is limited in terms of how to encourage appropriate care and treatment among MSM and other sexual minorities. Healthcare worker training was identified as a priority intervention to support the provision of essential services for MSM.

Existing strategies in sub-Saharan Africa have until now focused on heterosexual transmission – a decision that the research authors suggest is the wrong approach to ensure successful interventions to thwart the spread of HIV.

The higher biological risks of HIV acquisition and transmission associated with unprotected anal intercourse compared to other forms of sexual intercourse require a more nuanced approach; one study, from Malawi, identified high-risk behaviours within its small sample of MSM including inconsistent condom use (32.5%), transactional sex (23.7%), low exposure to HIV messaging (17.5%) and a low history of HIV testing (58.8% ever tested).

Imprisonment was also identified as a specific high risk factor for transmission of HIV among MSM, in studies originating in Malawi and Swaziland. This was attributed both to the confined setting and the riskof transactional or coercive sex as well as the low availability of condoms and lubricants – commoditiesthat, when used properly together, can help reduce the risk of HIV transmission.

One of the more interesting and intuitive conclusions from the studies related to the complicated nature of identity and self-identification of homosexuality among men in sub-Saharan Africa. Diversity in sexual orientation and practice among men on the continent make self-identification complicated which, in turn, complicates outreach and intervention efforts.

A study from Swaziland elaborated on this concept, with a majority of the sample of participants choosing to identify as homosexual or bisexual, but among them one-quarter of the participants also identifying as female. One third of those included in the study reported having had both male and female sexual partners in the previous 12 months.

The studies also took pains to highlight small victories being made across the continent to address and overcome the marginalization of sexual minorities. Community-based approaches in South Africa have had modest success in reaching marginalized populations with HIV outreach and prevention services, using peer education and the facilitation of safe social spaces to provide HIV education, address stigma and behavioural risks and link individuals into HIV testing or care. Similar strategies have been used to reach MSM with HIV research, HIV-prevention information, and HIV counseling and testing.

Without addressing this underserved, stigmatized population of MSM in sub-Saharan Africa, the editors concluded, it will be difficult to slow or halt the transmission of HIV. The researchers uniformly argued for better and more complete data about the demographics of the populations of sexual minorities to ensure better targeting of the continuum of care for HIV, beginning with prevention and moving into treatment.

*This article is also available in French. Article disponible en français.

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