

This is one of an initial five Policy Briefs developed by the Centre for Sexualities, AIDS and Gender at the University of Pretoria for the Irish Embassy Pretoria as a follow on to training provided by the Centre to Irish Aid personnel at the University from 18 – 21 April 2016. The aim of these Policy Briefs is to expand briefly on a core topic area relevant to the intersections between HIV and AIDS, gender, gender-based violence and sexualities, providing the reader with a brief background, an examination of key issues and setting out challenges for those working in the field.

Context

Many of the countries in eastern and southern Africa (the ESA region) fall into what is called the “epicentre” of the global HIV epidemic. While there is some cautious optimism about declines in incidence, rise in treatment access and suggestions of behaviour change (and the uptake of other prevention options) taking place, HIV has been devastating in its impact and still represents a development challenge of major proportions.

It is critically important to acknowledge that HIV is at the heart of people’s life struggles in the region – factors implicated in its spread include economic impoverishment, migration, transactional sex, gendered and generational inequities, deficiencies in health and health systems, living in hazardous conditions, lack of access to medical care, being socially, legally or sexually marginalised, and living within systems of patriarchy.

HIV, its causes and its consequences provide an opportunity for countries to reflect on their social, economic, political and legal realities, and to make the necessary changes in these not only to address HIV vulnerability but also to contribute to the development of societies which recognise and value all citizens.

Significant funding for the HIV and AIDS response in the region has come from the Global Fund and the US President’s Emergency Plan for AIDS Relief (PEPFAR), in some cases enabling roll-out of treatment programmes that would otherwise have been impossible. While contributions have also come from other donors, enabling a range of other interventions from the state and civil society, there are suggestions of donor fatigue in the context of a global economic recession, requiring in-country responses and contributions to be more innovative. Additionally, the broader political

dynamics in donor countries and these countries’ particular approaches to HIV and AIDS may have an influence on the way HIV funding is distributed and expected to be used.

Yet the global push, driven by UNAIDS, is for ambitious targets to “end the epidemic” by 2030.

For 2020 the targets are:

- 90% of people living with HIV will know their status
- 90% of people diagnosed with HIV will have access to sustained ART
- 90% of people receiving ART will achieve viral suppression

Each of the targets will rise to 95% by 2030.

What this introduction shows is that we have a scenario where we can acknowledge some success but also see that many challenges in prevention, care and treatment remain, and it raises questions about whether it is possible to “test and treat” our way out of the epidemic or if we have the courage to say halting HIV requires a new paradigm.

Many people with HIV in the African region have never been tested and do not know their status. We also know that some individuals do not come forward for testing even when it is freely available, or may even “drop out” of care and treatment programmes immediately after diagnosis. If the health needs of such individuals are to be addressed, much more needs to be known about the daily lives and psychological concerns of such individuals.

Studies have shown, for example, that some people living in high prevalence settings for HIV can be especially fearful of a positive diagnosis, given their expectation of painful sickness and an early death. Individuals are also afraid of rejection by significant others or stigmatisation by the wider community. These fears vary according to many factors, including gender and sexual identity. Men who have sex with men (MSM), for example, may be constrained by the fear of double discrimination resulting from illness combined with homophobia. The recent legislation in some African countries, notably Uganda, shows how realistic such fears are. Additionally, an unequal distribution of power within a sexual relationship may cause some to feel unable to, or fearful of, asserting their own agency. Although this is not always the case, younger girls

who are in relationships with older men at times find themselves, for example, socio-economically dependent on their partner and thus have little power to negotiate within the relationship.

With regard to women, since they are likely to be diagnosed first, often through antenatal care, they risk being “blamed” by their partners for introducing HIV into the relationship, and may be beaten or even abandoned. Women who are diagnosed at the same time that they learn that they are pregnant face difficult decisions about their future. The complexity of these issues is often overwhelming: failure to comply with the advice of health-care workers cannot be explained away simply as irrationality on the part of “non-adherent” service users. Once more, for example, women who are financially, socially or otherwise dependent on their partner may find themselves feeling that they have little choice with regard to decisions about their own sexual and reproductive health.

As for young people, they are disproportionately affected by HIV globally.¹ Twenty five percent of infected persons are between 10-24 years and

those aged 15-24 comprise 35% of new infections, resulting in 900,000 new infections annually. The greatest burden of HIV among young people is in sub-Saharan Africa (SSA). Here, young women have almost eight times the HIV prevalence as same-age men and their annual HIV incidence is an estimated 8%.

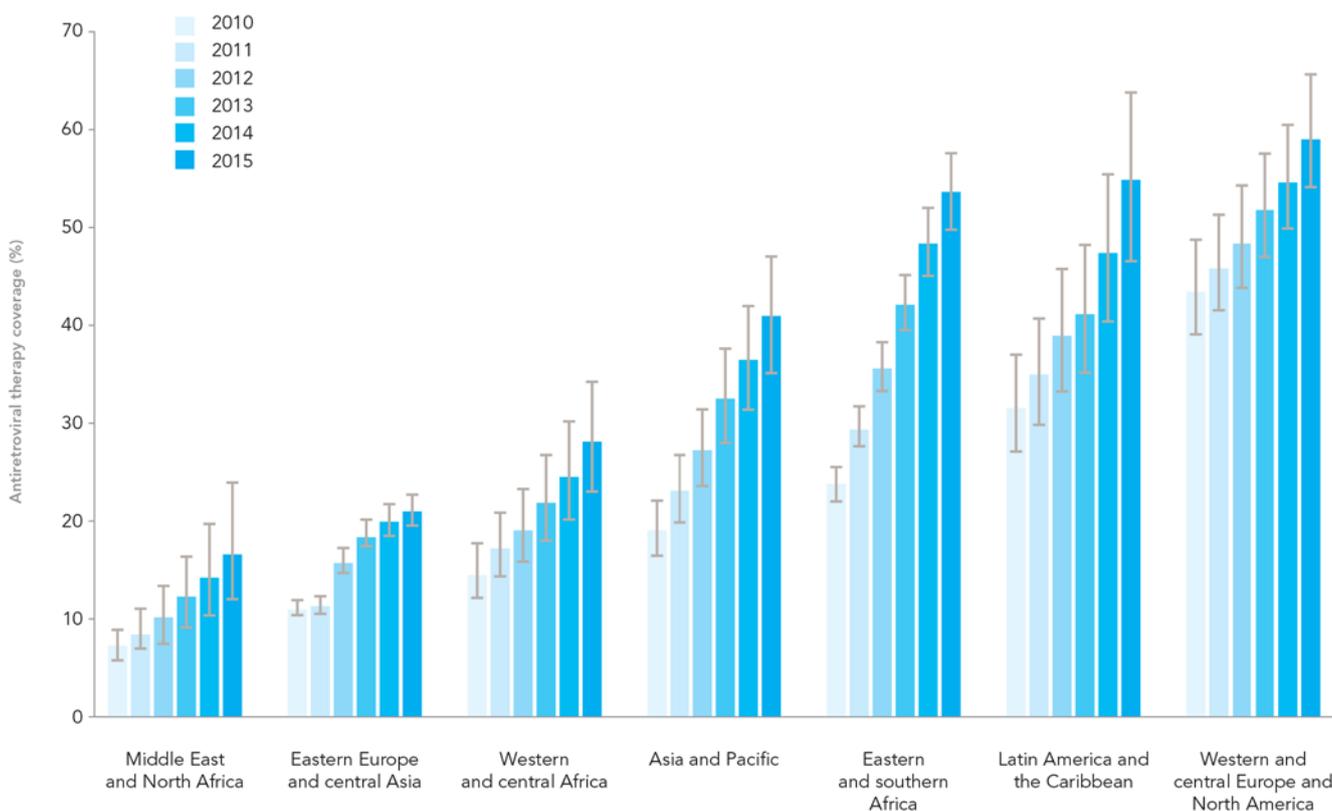
As Pettifor *et al* note,² despite the high risk of HIV transmission among young people, few rigorously designed prevention interventions with HIV endpoints have been evaluated. Many interventions focus on changing individual-level behaviors rather than addressing the larger contextual and structural landscape within which young people live. Further, few studies have explored the use of biomedical interventions among young people. While biomedical prevention offers considerable promise, further research is needed to determine the applicability, safety and efficacy of these approaches among youth. The factors affecting HIV risk are complex and will require a combination approach incorporating a supportive behavioral, structural and /or biomedical intervention

Economic inequalities also matter. About 95% of new cases of HIV now occur in low-income or middle-income countries, where the cost of drugs

1 Pettifor A, Bekker L-G, Hosek S, et al. Preventing HIV among Young People: research priorities for the future. *Journal of acquired immune deficiency syndromes* (1999). 2013;63(0 2):S155-S160. doi:10.1097/QAI.0b013e-31829871fb.

2 *Ibid*

Antiretroviral therapy coverage among people living with HIV, by region, 2010–2015



Sources: GARPR 2016; UNAIDS 2016 estimates.

and travel to a clinic can be heavy, and clinic visits may interfere with opportunities to earn a living. Food insecurity and other challenges of living in impoverished conditions also make it difficult to take drugs as medically mandated.

The relationship between HIV and poverty is not simple. However, the material circumstances of people's lives play an important part in shaping their risk of infection with HIV, and also their capacity to take care of themselves and access care from others.

The social context of the HIV epidemic demands a profound need for interdisciplinary collaboration, with social scientists playing a key role alongside biomedical scientists whose focus is on the medical and biological aspects of HIV.

Evidence

Recent statistics and evidence on HIV in Eastern and Southern Africa indicate that:

- In 2015, there were 19 million people living with HIV in this region, of which more than half were women
- In 2015, there were an estimated 960 000 new HIV infections (46% of the global total), but these had declined by 14% between 2010 and 2015
- It is estimated that 10.3 million people were accessing antiretroviral therapy, representing 54% of all people living with HIV in the region
 - 59% of adult women (aged 15 years and over) and 44% of adult men were accessing antiretroviral therapy in eastern and southern Africa in 2015.
- About 470 000 people died of AIDS-related causes in 2015, but between 2010 and 2015 the number of AIDS-related deaths fell by 38%
- There were 56 000 new HIV infections among children in 2015, but since 2010 there has been a 66% decline in new HIV infections among children in the region.
- In the case of so-called “key populations” (KPs), socially marginalised people are more affected by HIV than the general population. Compared with other adults of reproductive age, HIV prevalence is:
 - 12 times higher among sex workers
 - 28 times higher among people who inject drugs,
 - 19 times higher among gay men and other men who have sex with men (MSM)
 - 49 times higher among transgender women than among the general population.

As noted in the Context section above, “test and treat” as a key HIV prevention strategy relies on individuals coming forward for testing, accepting the result, starting treatment, staying on treatment, and adhering properly. The diagram below shows how challenges remain in making this a reality. In order to make mass testing and treatment campaigns more effective, it is imperative that we develop a better understanding of the social and lived realities of communities.

Strategies

According to UNAIDS, there is an urgent need to “fast-track” what has been called “combination” prevention.

Definitions of combination prevention vary – one approach describes combinations of biomedical or public health interventions (including upscaling HIV testing, condom provision, immediate initiation of antiretroviral therapy (ART) after diagnosis, and pre-exposure prophylaxis (PrEP) – with the addition of interventions for specific populations, such as needle-exchange and opioid substitution therapy programmes for people who inject drugs and voluntary medical male circumcision (VMMC) for heterosexual men).

Another speaks of combining these more biomedical interventions with a range of social and structural interventions (including forms of social and economic protection and empowerment, decriminalisation of illegal activities, building of human rights cultures and stigma mitigation efforts, addressing gender based violence and patriarchal beliefs and systems, community building and social cohesion development, health systems strengthening, meaningful mental health and ART-adherence support, exploring protections for migrants and mobile populations, and understanding the role of intergenerational relationships).

While Treatment as Prevention (TasP) is factored into many plans to address HIV, there is a reasonable consensus that we cannot simply test and treat our way out of the epidemic and that addressing the social and structural drivers, enablers and barriers of behaviour change requires a meaningful financial, programmatic and intellectual effort, including from researchers, academics and donors. Moreover, a more biomedical approach which excludes social and structural drivers, is likely to be cost intensive. Research in South Africa has shown, for example, the complexities of effectively managing the costs of TasP. Over and above the massive ongoing costs involved in biomedical approaches, these approaches are regularly critiqued for not addressing the socio-political and economic

structures that underpin the lives of many of those who find themselves in high risk groups. As Prof Peter Piot, the first executive director of UNAIDS and director of the London School of Hygiene and Tropical Medicine, remarked, “We will not end HIV as an epidemic just by medical means. People are not robots. Sex happens in a context. It is about power. Southern African girls and young women are infected by men who are much older than themselves. It’s about poverty. It’s also about a culture of machismo. There are also gay men all over the world who are discriminated against and underground, and there’s no way you can prevent infections if something is underground.”

There is also consensus that this kind of work needs to go where the epidemic is concentrated and sustained, in pockets of high rates of HIV transmission. These include key populations (in particular, female, male and transgender sex workers and their clients, men who have sex with men, and people who inject drugs) and, mostly in Eastern and Southern Africa, young women and their older male sexual partners. The trick is to do this in ways which recognise the issues these key populations face without stigmatising and essentialising them, reducing all people in that population to one single (or essential) characteristic (see the Policy Brief on Intersectionality for a deeper analysis of this).

From a technocratic, service-delivery perspective, there is a need for ongoing innovation for example better condoms, new and long-acting ARVs, better linkages to and between community-based services, including the home as a site of service delivery, along with creative use of social and other media.

The SADC HIV and AIDS Framework for 2010 to 2015, in need of updating, nevertheless remains a useful set of ideas. It locates HIV in a development paradigm and identifies HIV and AIDS, gender and poverty as crosscutting issues that are mainstreamed into all key intervention areas.

The framework recognises that social circumstances, including social norms, discrimination, gender inequalities, male dominance in sexual decision making and high levels of sexual violence reinforce HIV prevalence in the region. Following from this recognition, the guiding principles of the framework include gender sensitivity, a commitment to human rights and participation by marginalised groups.

Although women are disproportionality marginalised across the region, it is important that a focus on women in the policy environment does not displace the needs of many gender non-conforming people who are also marginalised by the gender system.

Critiques and challenges

Funding

Funding remains an ongoing challenge. The ESA region accounts for a large part of the total AIDS resource gap in low- and middle-income countries: while domestic funding for HIV has risen in recent years, dependency is still a major challenge for countries in the region. Reliance on donor funding for most countries in the region prompts concerns about the sustainability of their HIV responses and underscores the importance of countries focusing on long-term predictable sources of HIV financing.

Several countries are experiencing a decline in external resources, likely to have profound implications for their HIV programmes. Lifelong HIV treatment constitutes a financing challenge that will extend well into the future. The decline in external support, coupled with shifting donor priorities, threatens the gains achieved over the past two decades, increases the risk of service delivery gaps, and intensifies the competition for funding between various public health priorities. It is critical to note that of the total funding pool very limited amounts are available for research and institutions of higher education.

The impact of our prevention “language”

Reflecting on the history of HIV prevention, two narratives seem to emerge: a biomedical narrative and a social narrative. The focus of prevention in the biomedical narrative is on individual members of populations who are understood as rational individuals with decision making power who, when counselled by experts, adopt the prevention technologies advocated or change their behaviour to reduce HIV transmission. Within this narrative, failure to change behaviour is interpreted as an individual badness or weakness, or as a result of some “vulnerability” brought about by a complex “social structure” such as poverty or gender, seeing that person as completely powerless.

The social narrative, rather than focusing on individuals, is concerned with relations between persons and on how sexual and other practices that place persons at risk for HIV transmission are produced as well as transformed to reduce risk. The focus here is on communities and networks and the manner in which these collectives interact with the virus, with medical systems and cultures, and with the state and other institutions, and are thus enabled (or not) to respond effectively and sometimes creatively to the threat of HIV and AIDS.

The prevention “language” we adopt shapes where we put our time, energy and money. We argue in this Policy Brief for the idea that a biomedical

approach alone cannot work and that we need to understand and address the social and structural factors which shape human choices and actions. We would call this a true “combination” approach (see below).

Inclusive and combination approaches

As noted above, there is much enthusiasm for biomedical prevention (technologies), as is evident in the “fast-track” approach by UNAIDS, which is based on the idea that social and behavioural scientists have failed to bring about delayed sexual debut, a reduction in number of sexual partners and increased condom use, amongst others.

We argue that the distinction between “biomedical” and “social” is artificial. All biomedical technologies or tools have to be adopted and, with the exception of male circumcision, sustained by human beings living complex personal and social lives. Their beliefs, values, practices and “ways of being” impact on how they see, use and adapt biomedical interventions.

So any prevention strategy can be said to be biomedical *and* behavioural, *and* social *and* structural: it needs modifications to behaviour or practice but, more importantly, the active engagement of people in communities. Effective prevention requires that biomedical technologies, behavioural strategies, and social structures are not treated as separate prevention approaches. Combining these entities or approaches is seen as true combination prevention.

Issues to flag

- It is unlikely that a “magic bullet” for HIV prevention will be found, supporting the idea of “combination” prevention.
- Commitment to human rights-infused HIV prevention is wavering, and requires new energy, especially in light of the rise of new forms of homophobia.
- Civil society participation in prevention, treatment and care is not negotiable, and the participation of vulnerable populations and the recognition of diverse communities and contexts are very important.
- Theoretical and methodological innovation often arises out of difficult circumstances, leading to new forms of health promotion and care.
- South/south collaborations are often downplayed, yet opportunities exist for creative work out of the mainstream gaze and funding streams – we can learn from other African countries and other countries in the Global South.
- Ensuring HIV remains a focus in the post-

2015 development agenda is critical – health needs to be seen as a political issue not just a technical one.

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