Putting LGBTI on the Agenda of HIV and AIDS Programming in Africa

2008

POLICY BRIEF

SAfAIDS Southern Africa HIV and AIDS Information Dissemination Service

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EXECUTIVE SUMMARY

Unprecedented investments have been made into HIV and AIDS prevention, care and treatment strategies during this decade. These investments have produced encouraging results in many regions and this is a demonstration of what can be achieved when there is global resolve, political commitment and active engagement of people living with HIV and affected communities. However, these positive trends have not included some of the most vulnerable groups such as lesbians, gays, bisexual, transgender and intersex (LGBTI) communities in Africa. An interlocking set of human rights violations and social inequalities is responsible for fuelling HIV infection amongst same-sex practicing men and women in Africa. Despite increasing evidence of the need to design and implement HIV prevention, treatment, care and support interventions that deliberately target LGBTI and same-sex practicing persons, only a handful have been put in place in the past two decades.

CONTEXT

Although the impact of HIV and AIDS on the general population in Africa is well-documented, little research has been conducted to establish the role of same-sex HIV transmission in Africa. Studies conducted in Senegal, Ghana and Kenya indicate significantly higher HIV seroprevalence rates amongst men who have sex with men than in the general population (Cary Johnson, 2007). Far less research has been done to establish the impact of HIV and AIDS on lesbians. Recent studies are indicating that the majority of African men who have sex with men also have sex with women - two thirds or higher, according to some studies (Onyango-Ouma, Biringi & Geibel, 2005; Wade et al., 2005; Angala et al.,

2006). Once HIV is introduced into networks of men who have sex with men, the virus is therefore also likely to be transmitted to their female partners (given the typically low rates of condom use between regular partners), and subsequently to their newborn babies (van Griensven, 2007).

Women who have sex with women are often socially required to stay in sexual relationships with men, because their right to sexual and reproductive health is not recognised.

Women who have sex with women (WSW) are often perceived as being less at risk of HIV infection. However in Africa, traditional norms and culture maintain the subordinate position of women. Women who have sex with women are often socially required to stay in sexual relationships with men, because their right to sexual and reproductive health is not recognised. This increases their risk of HIV infection.

UNAIDS admits that intervention is still very low in Africa and warns that without immediate attention to this human rights and public health crisis, efforts to effectively combat the AIDS pandemic in Africa may be seriously challenged, (UNAIDS,2006).

While we recognise the existence of trans-sexual and intersex people, we take a pragmatic approach that seeks to empower these groups to become more visible, through strengthening interventions around the existing LGB community, with which they interact.

POLICY ISSUES and GAPS

Inadequate Policies and Legislation

More than 85 countries across the world criminalise same-sex relationships and the majority are in Africa. The majority of national HIV and AIDS policies and strategic plans are generally silent about LGBTI issues.

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Uganda, Africa's role model in HIV prevention, care and treatment has not implemented a single HIV and AIDS programme targeting the LGBTI community in twenty six years of "programming excellence". In the process, such laws and policies increase the vulnerability of HIV infection among same sex practicing men and women and significantly contribute to their marginalisation.

Only South Africa, in the southern Africa region, has enacted LGBTI friendly legislation. The South African scenario has little to celebrate though, as the positive legislation is being overshadowed by a community that is homophobic and has witnessed lesbians being murdered due to their sexual orientation and preference. Sizakele Sigasa and Salome Massoa, lesbians living in Soweto, were brutally murdered on 7 July 2007 due to their sexual orientation. The lack of a conducive LGBTI policy and legislative environment has resulted in failure by the LGBTI communities themselves to come into the

open, organise themselves and mobilise stakeholders to address their epidemic related concerns. Whilst the gay, lesbian and bisexual communities have become more visable in recent years, transgendered and intersex persons remain largely invisible in southern Africa. Stakeholders in the HIV and AIDS arena have, on their part, failed to identify the unconducive enviroment and have not established a systematic support mechanism to unlock the challenge.

Inadequate LGBTI Specific AIDS Responses

One of the key lessons drawn from more than twenty years of HIV and AIDS programming is that well-designed and appropriately targeted programmes, implemented with support from public health and political leadership, can effectively reduce HIV transmission in communities most at risk of HIV. UNAIDS reports that, less than one in twenty men who have sex with men (MSM) across the world have access to HIV prevention, treatment, care and support services.

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The numbers are even lower in low-income settings in Africa. Sex between men is estimated to account for between 5 and 10% of global HIV infections - although the proportion of cases varies considerably between countries. Recent studies by OSISA/SHARP have indicated that unprotected receptive anal sex was reported as having the highest risk for HIV transmission. Reported condom use, although often higher than for sexually active heterosexuals, was often inconsistent and

remains relatively low. In 2008, despite the accumulation of more than a quarter of a century of knowledge of successful HIV interventions, homophobia and the criminalisation of homosexuality continue to be significant obstacles to the scale up of HIV prevention, treatment, care and support.

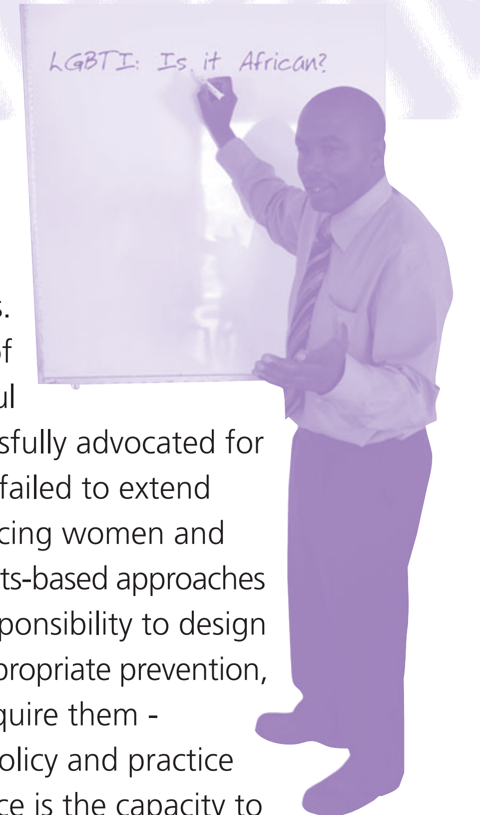
Inadequate funding for LGBTI interventions in mainstream HIV and AIDS programming

Internal homophobic stigma and denial within the majority of AIDS services organisations, at various levels, often combines with reluctance among major funding partners to provide resources towards addressing LGBTI issues in HIV and AIDS programming. The United States, one of the largest HIV and AIDS donors, has restrictive reproductive health policies that reinforce stigma and compromise sexual rights (Cary Johnson, 2007). UNAIDS estimates Africa will need US$353 million for HIV prevention activities for men who have sex with men for 2006-2008. The "Off the Map" report indicates that the total amount of funding currently committed will be less than US$2 million. "Unless there is a dramatic increase in resources, less than one percent of the needs of African same-sex practicing men will be met. Virtually no funding is currently available for HIV prevention programmes for same-sex practicing women" (Cary Johnson, 2007).

Homophobia and stigma driven by the foot-soldiers of HIV and AIDS

Culture, religion, socialisation, stigma and denial among HIV programmers and service providers, have resulted in the development and implementation of legislation, policies and programmes that are LGBTI

blind across the African region. As a result, the LGBTI community has become “invisible” in treatment, care and support interventions at all levels.



HIV programmers and service providers have been at the forefront of efforts that have resulted in HIV being recognised and addressed at community, national, regional and global levels over the last two decades. More importantly, service providers have assisted in bringing the cause of people living with HIV to prominence and advocating for their meaningful participation in HIV programming at all levels. Programmers have successfully advocated for the adoption of a rights-based approach to HIV programming, yet have failed to extend this approach to address HIV transmission issues among same-sex practicing women and men. There is need to put aside the tensions between public health and rights-based approaches and any personal issues around morality. HIV service providers have a responsibility to design and implement service provision that will result in unhindered access to appropriate prevention, treatment, care and support services to all community members who require them - regardless of their sexual orientation and preferences. Service provider policy and practice need to clearly reflect this non-discriminatory stance. Of equal importance is the capacity to develop HIV and AIDS programmers with the requisite knowledge and skills that will enable them to confront their own homophobic stigma, and to design and implement comprehensive services to meet the HIV prevention needs of the LGBTI community.

KEY RECOMMENDATIONS

1. HIV and AIDS Programmers

HIV and AIDS programmers should initiate programmes that deliberately target LGBTI communities through undertaking appropriate consultations with LGBTI organisations in order to define the scope of the HIV prevention, treatment, care and support services required. HIV and AIDS service providers should equip their staff with appropriate knowledge and skills to effectively respond to the AIDS related service needs of the LGBTI community. They also need to target legislators and policy makers to ensure the repeal of laws that criminalise same-sex sexual conduct.

Laws and policies that criminalise same-sex consensual sexual conduct must be repealed in line with international human rights laws.

2. Policy makers

Legislators and policy makers at country level should ensure that all laws and policies that criminalise same-sex consensual sexual conduct are repealed in line with international human rights laws. Hostile legislative and policy environments significantly contribute to the marginalisation of the LGBTI community and increase their HIV vulnerability.

3. Funders

Funding partners should support advocacy for the repealing of laws and policies that criminalise same sex practices. Increased resources should be allocated to governments and civil society organisations that are prepared to implement HIV prevention, treatment, care and support programmes to meet the needs of the LGBTI community. Partners should support LGBTI related research in order to build an information base that will guide programming and result in improved availability and access to comprehensive AIDS related services.

HIV DOES NOT DISCRIMINATE
DO YOU?

CONCLUSION

As has been demonstrated in many different countries, reducing the social exclusion of LGBTI communities through the promotion and protection of their human rights (including sexual rights and the right to health) is not only consistent with, but a prerequisite to, good public health. Once discriminatory policies are abolished and stigma and discrimination are confronted, country-based programmes can be put in place to encourage the LGBTI community to stay free of HIV infection, thus supporting national goals of reducing the HIV burden.

A stronger LGBTI community is central to efforts targeted at raising the profile of its epidemic-related challenges, and also offers the opportunity to open up prevention efforts towards those groups which interact with the LGBTI community even though they do not identify themselves as homosexual. Many African men who have same-sex relationships are also married and this poses double risks, which they need to be made aware of. Thus stakeholders need to strongly support current LGBTI leaders in order to facilitate the emergence of a stronger movement, through promoting role models and resisting their own fears of being stigmatised by association.

REFERENCES

1. Cary Alan Johnson, Off the Map, IGLHRC, 2007
2. United Nations, United Nations Secretary General Report, Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals, 2008
3. GALZ, Unspoken Facts-A history of Homosexuals in Africa, 2008
4. www.yogyakartaprinciples.org
5. www.ilga.org/news
6. Accelerating-Prevention eForum (http://www.healthdev.org/eforums/cms/inv-archives.asp?sname=Accelerating-Prevention)
7. UNAIDS, 2008, Sub-Saharan Africa AIDS Epidemic Update, Regional Summary

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