Achieving an AIDS-Free Generation for Gay Men and Other MSM in Southern Africa

Executive Summary

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Executive Summary

Introduction

The HIV epidemic among gay men and other men who have sex with men (MSM) is expanding. Prevention, treatment, and care programs funded to reverse the epidemic often neglect this population. Stigma and discrimination against MSM flourish with impunity in countries that receive significant donor funding for HIV. National planning documents and donor funding agreements mention MSM, but little programming actually exists. Epidemiological surveillance that would help inform programs serving MSM lags far behind strategic information collected on other populations. Little to no attention is paid to the needs of transgender people.

This is the current state of HIV among gay men, other MSM, and transgender individuals (GMT). While the global conversation focuses on novel approaches to HIV treatment and prevention, GMT struggle to obtain the most basic health services. They are isolated, criminalized, blackmailed, and beaten.

Despite this, GMT communities in southern Africa have shown great resilience and determination. In each country studied, numerous community-led programs supported by both large and small donors are making substantial inroads against pervasive stigma and discrimination.

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These are the findings of the second report in this series: *Achieving an AIDS-Free Generation for Gay Men and Other MSM*. Focused specifically on six countries in southern Africa (Botswana, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe), this report describes the financing and implementation of programs for GMT in a region at the heart of the HIV epidemic through a combination of desk research and in-country consultations conducted by civil society advocates with implementers, policy makers, academics, and people living with HIV.

Photo: Chris Vail

HIV prevention education is one of the services provided by the Center for the Development of People (CEDEP) in Malawi.

These six countries have made significant progress in reducing the number of new HIV infections among their adult populations, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS). Over the past 10 years, the number of annual new infections has dropped substantially, with declines ranging from 25 percent in Swaziland to as much as 63 percent in Botswana. This is not a small accomplishment and comes as the result of persistent, concerted efforts by national governments, donor countries, program implementers, researchers, and civil society.

The same level of effort is required to change the trajectory of the HIV epidemic among GMT. Currently, national governments spend almost no public money on programs for GMT globally, according to UNAIDS. This leaves a patchwork of isolated interventions sponsored by international donors that is inadequate to prevent further expansion of the epidemic. As these donors transition towards increased country ownership, the little money that is dedicated to this population is under threat. If new resources were directed to a combination of behavioral, biomedical, and structural interventions, hundreds of thousands of lives would be saved.

However, the true impact of these efforts can never take shape without addressing the realities of life for GMT in southern Africa. Human rights violations permeate every facet of life for these men and women, and the lack of robust engagement by donors, implementers, and governments has only perpetuated further abuse. Real efforts to increase donor and national government engagement in preventing and treating HIV infection among GMT must include comprehensive human rights programming that addresses stigma and discrimination.

Donor Financing and Support

This report finds a striking incongruence between donor policy and funding patterns. The top two funders of HIV/AIDS programs globally—the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—have clear policy commitments to addressing the epidemic among GMT. PEPFAR's *Blueprint for an AIDS-Free Generation* and the Global Fund's strategy in relation to sexual orientation and gender identities (SOGI) make a concrete case for the need, type, and scope of investments in programs serving GMT. However, the research in this report shows that funding and implementation come nowhere close to upholding these policy commitments.

Though **PEPFAR** and other financing mechanisms under the U.S. Department of State have gone to great lengths in recent years to target new funding opportunities to programs that support GMT, resources allocated do not approach potential need. The six countries profiled in this report comprised 10 percent of total PEPFAR funding between 2007 and 2011, but four of the six annual budgets contained no programming for MSM. When included, budgeted amounts were difficult to decipher, frequently miniscule, and often shared among multiple populations, reducing the certainty that MSM were reached at all. There was no mention of transgender individuals.

The **Global Fund** has one of the most progressive donor policies in relation to GMT, delineating clear responsibilities for every actor within its financing model. However, of the $1.5 billion in funding allocated to these six countries since 2001, only 0.07 percent was for programs specifically targeting GMT. Moreover, the majority of this support is concentrated in just one of these six countries (Namibia). This percentage may not reflect the full demand from targeted programs in these countries as some proposals containing strong programs for MSM and other key populations were not approved for reasons other than technical merit.

The Global AIDS Response Progress Reports from **UNAIDS** remain the only global measure of progress against HIV among this population. Civil society representatives reported that UNAIDS is an important advocate for the needs of GMT in country. However, inconsistencies in the reported data obscure these reports' usefulness in strategic planning, and the absence of an accountability mechanism tied to the reports leaves little incentive for countries to achieve real progress.

Country Implementation

Civil society advocates studying the implementation of programs for GMT in each of these countries found:

In **Botswana**, criminalization, stigma, and discrimination have impeded equity goals that are built in to the country's national strategic plan. Positive change is happening, though, as some government officials speak openly about the need to work with MSM. The country is currently poised to be one of the first on the continent to finance HIV programs for MSM with public money.

A highly publicized trial of two men in **Malawi** arrested for attempting to marry brought considerable attention to the needs of GMT in 2010. Currently, the U.S. government and UNAIDS provide vital technical assistance and resource support to community-based service providers. Violence and discrimination within and outside of the healthcare setting remain major impediments despite high-level government commitments to change.

As an upper middle-income country, **Namibia** is seeing its share of donor resources dwindle. However, it is these donors, primarily the U.S. government, that have played a key role in maintaining MSM in national strategic frameworks and implementation plans. There is concern that the transition to full country ownership will happen without regard to the needs of this population.

LeGaBiBo (Lesbians, Gays and Bisexuals of Botswana) is the oldest LGBT organization in Botswana.

In **Swaziland**, governmental denial of the existence of GMT creates an environment in which it is difficult to know whether or not programs for GMT actually exist. It appears some condom and lubricant distribution programs exist, but are available in limited coverage areas in urban centers. Other reports indicate that programs designed for multiple key populations focus primarily on serving female sex workers. Governmental resistance to programs for GMT remains strong.

A coalition of nongovernmental organizations (NGOs) in **Zambia** struggles to deliver services and advocate in a legal environment that cripples the country's national HIV response. Harshly critical statements from religious leaders and respected clinicians further alienate and stigmatize GMT, limiting their willingness and ability to access prevention and treatment programs. Government corruption forced the transfer of donor money from public to private, religious implementers in 2010. That change has had significant, negative consequences for Zambian GMT.

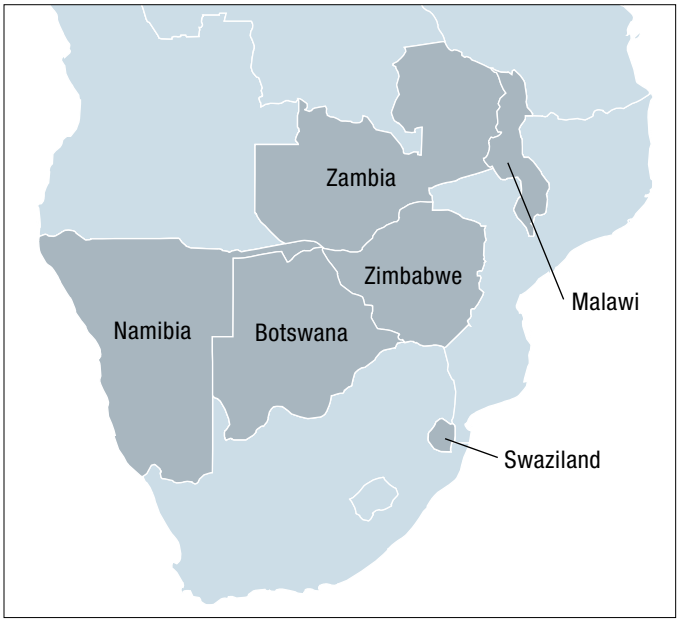
Police in **Zimbabwe** actively pursue and arrest those suspected of being GMT or working on their behalf. As in other settings, strategic documents with commitments to GMT are drafted with no real intent to carry them out. The deliberate effort by national authorities to associate same-sex sexual practices with Western culture has only further politicized this issue in Zimbabwe.

An AIDS-free generation will never be achieved without southern Africa and southern Africa cannot achieve an AIDS-free generation without greater attention to the needs of GMT.

Conclusion

Where programs for GMT exist in southern Africa, they attempt to address the urgent needs of the population living in the region. However, there are too few programs that have a transformative effect on the epidemic overall. Funding by donors and national governments is not sufficient to achieve real public health impact or evaluate outcomes. Attention must shift from global and national strategy documents to actual implementation—developing robust, achievable indicators for programs serving GMT, and building the evidence base around high-impact interventions.

Being strategic on HIV requires greater attention to implementing programs for GMT and other key populations in southern Africa. An AIDS-free generation will never be achieved without southern Africa and southern Africa cannot achieve an AIDS-free generation without greater attention to the needs of GMT.



Recommendations

National Governments

- National governments should decriminalize same-sex sexual practices and support programs that reduce stigma and discrimination against marginalized groups. Donors should actively support such efforts through diplomatic channels and funding for civil society groups working on these issues.
- National governments should be encouraged to develop implementation plans that operationalize national strategic frameworks, a step that would increase the likelihood that the commitments to GMT in those documents are actualized.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

- PEPFAR should institute clearer budgeting and reporting practices that make the implementation of national strategic plans and the allocation of resources more transparent.
- PEPFAR should develop benchmarks that guide the transition to country ownership and the inclusion of key populations, especially GMT.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

- The Global Fund should implement the SOGI strategy in southern Africa by helping countries reprogram existing grants to address the needs of GMT in the region and by instituting stronger accountability mechanisms to ensure that approved programs are actually implemented.
- The Global Fund should ensure that GMT are appropriately represented on country coordinating mechanisms (CCMs) and provide those bodies with any technical support required to address the needs of GMT.

The Joint United Nations Programme on HIV/AIDS (UNAIDS)

- UNAIDS should reform the Global AIDS Progress Reporting process to make it more relevant to the needs of implementers, policy makers, and civil society.
- UNAIDS should improve the quality and scope of the technical assistance it provides countries by increasing the number of staff with expert knowledge of issues related to key populations, particularly GMT.

Strategic Information

- All countries receiving international assistance for HIV should conduct biennial epidemiological surveillance that includes key populations, especially GMT.
- All donors should fund implementation science and operations research that will build the evidence base for effective delivery of combination prevention and treatment services to GMT.

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