2019

Key Populations Advocacy Brief

EMORY UNIVERSITY | ST. PAUL'S UNIVERSITY | UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

Photo: PSI

Overview

Globally, key populations account for 40 percent of new HIV infections, even though they make up a much smaller proportion of the total population.[1] The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) identify key populations as: gay men and other men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SWs), transgender persons (TG), and prisoners.[1] Many people at the highest risk for HIV do not fit neatly in single risk behavior categories, however. Both female and male sex workers may be involved in transactional sex to pay for drugs. Some men who have sex with men use drugs to enhance sexual encounters. Finally, men who have sex with men may be in a marital relationship or have female partners as well.[2] Globally, the rates of key populations accessing high-quality, safe, effective HIV and AIDS services are low, while stigma and discrimination and gender-based violence are high.[3] Fears of stigma, backlash, discrimination, gender-based violence, criminalization, and fear of breach in confidentiality hinder key populations accessing testing, care, and treatment.[3]

In an effort to support partnerships with faith-based organizations (FBOs), UNAIDS and PEPFAR are carrying out programs to sustain FBO's contributions and increase their service capacity to ensure that FBOs are at the forefront of global efforts to end the AIDS epidemic by 2030.[4]

Whenever AIDS has won, stigma, shame, distrust, discrimination and apathy was on its side. Every time AIDS has been defeated, it has been because of trust, openness, dialogue between individuals and communities, family support, human solidarity, and the human perseverance to find new paths and solutions."

— MICHEL SIDIBÉ, EXECUTIVE DIRECTOR,UNAIDS

"While many people with HIV are now enjoying strong, healthy, full lives; urgency and collaboration are needed to ensure dignity, decency, and survival for the many more people living with HIV and key populations still struggling."

— DR. LAUREL SPRAGUE, EXECUTIVE DIRECTOR,GNP+

"Communities of faith play important roles in setting and changing social norms and influencing public policy and legislation. This influence has played out in both positive and negative ways in the response to HIV."

— SARA SPEICHER, WCC-EAA

"To end AIDS deaths by 2030, we need to address the stigma that keeps people from testing, keeps them from taking their medication and keeps them from disclosing their statuses."

— JULIAN HOWS, GNP+ AT THE "FAITH ON THE FAST TRACK AIDS 2016" PRE-CONFERENCE MEETING TO THE INTERNATIONAL AIDS CONFERENCE

"Without more domestic investments and international assistance, we cannot push faster on the Fast-Track. More people will become infected with HIV and lives will be lost. Without more community health workers, health systems will remain stretched. Without changing laws, key populations will be left behind."

— MICHEL SIDIBÉ, EXECUTIVE DIRECTOR, UNAIDS

You have no right to deny someone a service. I think it would help if Faith Based Organizations could be like Jesus welcoming everyone. Jesus would welcome sex workers and encourage them. This is what God expects and probably that is what would help us get to zero new infections"

— DIRECTOR OF A LOCAL FBO IN ELDORET, KENYA

The Challenge in Front of Us

The criminalization of and discrimination against behaviors and activities related to sexual orientation and gender identity create systemic challenges and barriers to providing and receiving care.[2] When members of key populations experience stigma and discrimination, they are less likely to access HIV and AIDS prevention and care services. This is of concern because members of key populations are at higher risk for and have a higher prevalence of HIV.[5]

Furthermore, members of key populations living with HIV may be at higher risks for opportunistic infections and co-morbidities. For example, drug use has many potential co-morbidities such as hepatitis, tuberculosis, and mental illness which can impact overall health and complicate HIV medical management. In addition, drug use may negatively impact adherence to antiretroviral therapy (ART) and these lower rates of adherence may make ART less effective due to drug resistance.[2] Finally, the nature of transactional sex creates a higher risk for contracting and transmitting HIV and other sexually transmitted infections among sex workers.[6]

Roles of PEPFAR and UNAIDS

In response to the goal of ending the AIDS epidemic by 2030, PEPFAR and UNAIDS have launched the Key Populations Investment Fund (KPIF) and Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) program. KPIF will fund community organizations serving key populations and organizations led by members of key populations to "identify, measure, and change the complex dynamics driving stigma, discrimination, and violence as well as to expand key populations' access to and retention in HIV prevention, treatment, and care services".[1] LINKAGES aims to "accelerate the ability of partner governments, civil society organizations led by key populations, and private-sector providers to plan, deliver, and optimize comprehensive HIV prevention, care, and treatment services to reduce HIV transmission among key populations and help those who are HIV positive live longer."[7] To reach these goals, strengthening and expanding partnerships with FBOs is critical because they provide such a high percentage of HIV clinical services in many countries of the world with high HIV prevalence. However, members of key population communities may face barriers to accessing care in faith-based facilities because of religiously motivated stigma.[8] FBOs are deeply embedded community-based organizations that have the potential to reach people from key populations with HIV and AIDS care. Through partnership with UNAIDS and PEPFAR, FBOs can develop programs and services to reach key populations and use their own social power to advocate for respect and compassion, lowering barriers and increasing access to services that are friendly to key populations.[3]

Snapshots of Success

UNAIDS and PEPFAR's existing partnerships have been important in increasing access to care for members of key populations, and engaging faith and community leaders to address stigma and discrimination. Some of the current partnerships and programs are highlighted here:

1. *Expand understanding of current knowledge and attitudes towards key populations*
   Saint Paul's University, a member of the academic consortium working on the UNAIDS/PEPFAR Faith Initiative, conducted interviews and focus group discussions in Kenya to better understand the influence of religion on stigma and how faith-based health systems can minimize stigma and maximize support for members of key populations living with HIV and AIDS. Findings from this research will inform a curriculum to train FBOs and religious leaders on models of HIV care and support programs that reflect the needs and priorities of key population communities. The Christian Health Association of Kenya (CHAK), in partnership with Emory University's Interfaith Health Program, administered a survey to clinical providers at their HIV clinical sites to assess providers' knowledge and skills in providing high-quality clinical care to key populations in CHAK faith-based facilities. Understanding current attitudes and knowledge as well as the influence of religion on stigma is an important first step to addressing and minimizing the stigma and discrimination that many key populations face.

2. *Engage and mobilize faith and community leaders*
   A commitment to address stigma and discrimination has motivated partners such as the World Council of Churches—Ecumenical HIV and AIDS Initiatives and Advocacy (WCC-EHAIA) and Ecumenical Advocacy Alliance (WCC-EAA) to implement stigma reduction activities through direct engagement of religious leaders. Over 1,000 faith leaders around the world promoted HIV testing in their faith communities as a way to challenge the stigma that often accompanies HIV testing. WCC-EAA collaborated with UNAIDS Kenya, the Kenya chapter of the International Network of Religious Leaders Living With or Affected by HIV/AIDS (KENERELA+), and the

Men Engage Kenya Network (MenKen) using the Framework for Dialogue meetings for a joint HIV mobilization campaign to sensitize and mobilize male faith and community leaders. The campaign harnessed the clout of religious and traditional leaders to encourage uptake of HIV services among men. In Zambia, the WCC-EHAIA worked with Trans Bantu Zambia, a national LGBT advocacy organization, to help implement a Contextual Bible Study program and establish a safe spaces initiative. The Contextual Bible Study model re-examines religious texts that have been used to justify violence and discrimination toward members of key population communities by listening to the concerns and points of view of people from those communities.

3. *Develop partnerships and collaborations to provide HIV care services*
In Kenya, CHAK, the Kenya Episcopal Conference of the Kenya Conference of Catholic Bishops, and Supreme Council of Kenyan Muslims have developed formal collaborations for providing HIV primary care services specifically targeted to key populations. The International Network of Religious Leaders Living With or Affected by HIV/AIDS (INERELA+) has developed a "SAVE" approach to HIV prevention that offers an alternative to dominant faith-based HIV prevention strategies. The SAVE approach provides comprehensive information in contrast to many faith-based programs that emphasize abstinence and fidelity alone.[9] The SAVE approach provides a more holistic way of preventing HIV as well as providing additional information about HIV transmission and prevention. In this way, it provides support and care for those already infected and actively challenges the denial, stigma, and discrimination commonly associated with HIV.[3, 9] These inter-religious partnerships are essential to maximize limited resources and services from FBOs.

Opportunities Moving Forward

While UNAIDS and PEPFAR, in coordination with numerous local grassroots organizations, have been able to make tremendous strides in addressing HIV and AIDS in key populations, there is still a long way to go to reach the goal of ending the AIDS epidemic by 2030. In order to help ensure that the resources of faith-based partners can contribute to this goal, UNAIDS and PEPFAR are supporting the following initiatives:

1. *Continue assessing stigma and discrimination*
In different communities, attitudes, stigma, and discrimination towards members of key populations and those living with HIV look different. Continuing to assess attitudes and stigma is essential to minimizing discrimination. This includes understanding the influences of religion on stigma, and the attitudes and beliefs held by community members and clinical providers alike. When stigma and discrimination are addressed, members of key populations living with HIV may be more willing to seek the critical care they need.

2. *Equip and mobilize faith and community leaders*
Tailored and contextual actions to support religious leaders, activists, and scholars to articulate compassionate responses to HIV should be defined with key population networks. Training provided by the networks of key populations can be given to staff from FBOs, community service organizations (CSOs), and other community stakeholders on how to effectively work with key populations. Religious leaders who can serve as trusted allies and advocates for members of key populations should be identified. These leaders can also provide support and an example of respect to families of key populations in order to encourage acceptance rather than rejection.

3. *Build capacity for further dialogue*
PEPFAR and UNAIDS partners have been working extensively to create opportunities for dialogue with key populations about HIV and AIDS grounded in empowerment and respect for human rights, yet there is still a need to continue building capacity for these dialogues. In many countries and communities, there is opposition from religious communities to comprehensive sexuality education and information in schools. Creating opportunities for inter-generational dialogue about HIV prevention, sex, sexuality, and gender-based violence through contextualized bible studies and other similar methodologies is essential to take these conversations forward.

   There is also a need to create spaces for members of key populations who are also people of faith to describe their own religious and spiritual perspectives and engage them. Encouraging FBOs to include members of key populations in their administrative and programmatic structures will allow for greater communication, minimize stigma and discrimination, and maximize reach with and for key populations affected by HIV and AIDS.

4. *Increase funding to reach people at risk*
One of the largest barriers to FBOs providing care for and by members of key populations is a lack of funding and capacity of grassroots FBOs. Through increased funding, collaboration, and joint action between FBOs, CSOs, and local and national governments can expand access to HIV services to members of key populations. These networks will also help FBOs expand their programs and build capacity for continued care free of stigma and discrimination.

> *We, religious leaders participating in the dialogue between religious leaders and the LGBTI community gathered at the CARITAS Congo Reception Center; considering the stigma and discrimination that LGBTI suffer in our country, recognising that every human being is created by God in his image, and every person has the same right to be treated with dignity, take the commitment to advocate true love, to avoid stigmatisation and discrimination of LGBTIs; to adapt our religious discourse to realities; to inform and train people on the subject of LGBTI people in order to integrate them into Congolese society and to promote their access to health, education and social services.* – DECLARATION OF THE CARITAS RECEPTION CENTER 2017, DEMOCRATIC REPUBLIC OF THE CONGO

Source: *INERELA+ Annual Narrative Report 2017. http://inerela.org/wp-content/uploads/2018/06/Web-versionLORESspreads-1.pdf*

KEY POPULATIONS ADVOCACY BRIEF
SUPPORTING DATA

In 2016, outside of sub-Saharan Africa, key populations and their sexual partners accounted for 80% of new HIV infections.

80%
NEW HIV INFECTIONS

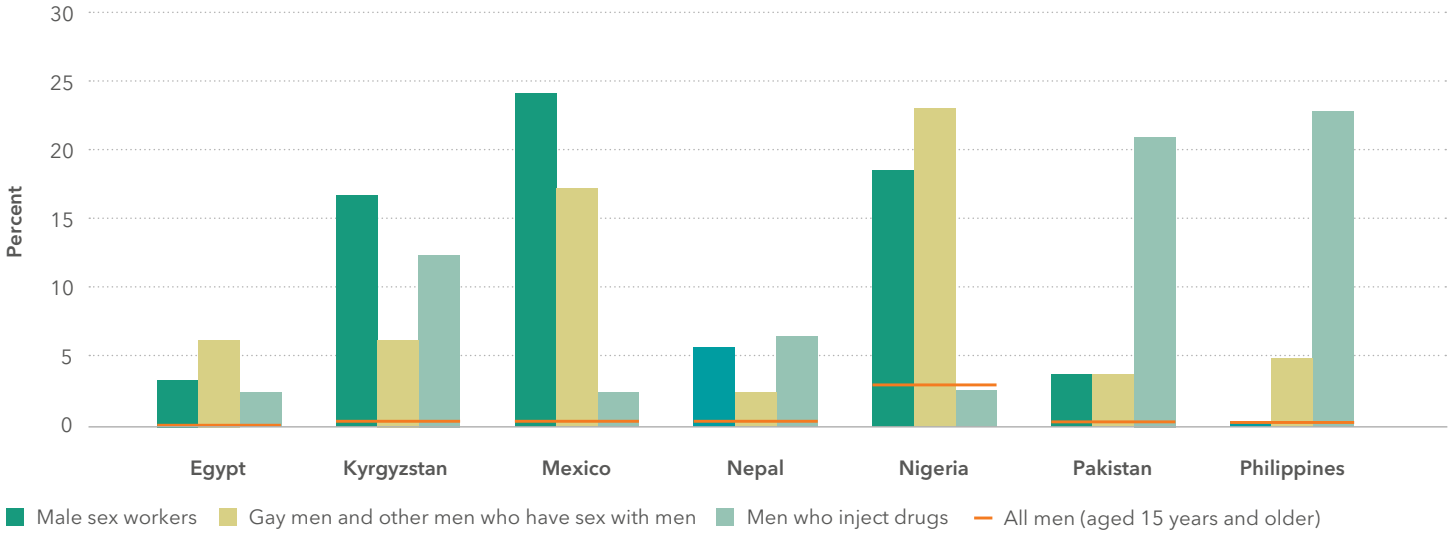
Even in sub-Saharan Africa, key populations accounted for 25% of new HIV infections in 2016

25%
NEW HIV INFECTIONS

Source: http://www.unaids.org/en/topic/key-populations

In all regions, HIV prevalence is consistently higher among men within key populations – including gay men and other men who have sex with men, male sex workers, clients of sex workers and men who inject drugs – than it is among the overall adult male population.

HIV Prevalence Among Male Key Populations and the General Adult Male Population (Aged 15 years and older) Selected Countries, Most Recent Data, 2014-2016



Source: UNAIDS. 2017. *Blind Spot: Reaching out to men and boys*. Retrieved from: http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf

Gay men and other men who have sex with men continue to share a disproportionately high burden of HIV infection: a UNAIDS analysis has shown they are on average 24 times more likely to acquire HIV than men in the general population.

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Key Messages

1. Members of key populations are at higher risk for acquiring HIV but have limited access to HIV and AIDS services because of stigma and discrimination, gender-based violation and criminalization.

2. While religion may contribute to stigma, some faith-based partners with support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) have worked to understand attitudes and stigma, mobilized faith and community leaders to address stigma and discrimination, and developed interfaith partnerships to maximize HIV and AIDS care services for members of key populations.

3. Moving forward, there is a need to continue exploring motivations behind stigma and engaging faith leaders to work with members of key populations to discuss stigma and develop activities to reduce it among their community members.

Overview

Globally, key populations—typically sex workers, gay men and other men who have sex with men, people who inject drugs, transgendered people, and populations in closed settings such as prison—account for 40 percent of new HIV infections, even though they make up a much smaller proportion of the total population.[1] They also have extremely low rates of accessing safe, effective, and high-quality HIV services where stigma and discrimination and gender-based violence are high.[2] In many communities around the world, faith-based organizations (FBOs) are addressing stigma and discrimination (including the stigma and discrimination that religion may support), and providing HIV care services to members of key populations.

The Contributions of Faith-Based Partners in HIV and AIDS Response

FBOs have an important role to play in the global response to HIV and AIDS. Through partnership with UNAIDS and PEPFAR, FBOs are able to develop programs and services to reach these key populations, making them key partners to achieving the global goal of ending the AIDS epidemic.[2] In addition, the marginalization of key populations and their vulnerability to HIV have caused some FBOs to re-examine their own faith traditions and teachings and ask hard questions about the role of religion in creating and maintaining stigma, discrimination and marginalization.

In all regions, HIV prevalence is consistently higher among men within key populations — including gay men and other men who have sex with men, male sex workers, clients of sex workers and men who inject drugs — than it is among the overall adult male population.

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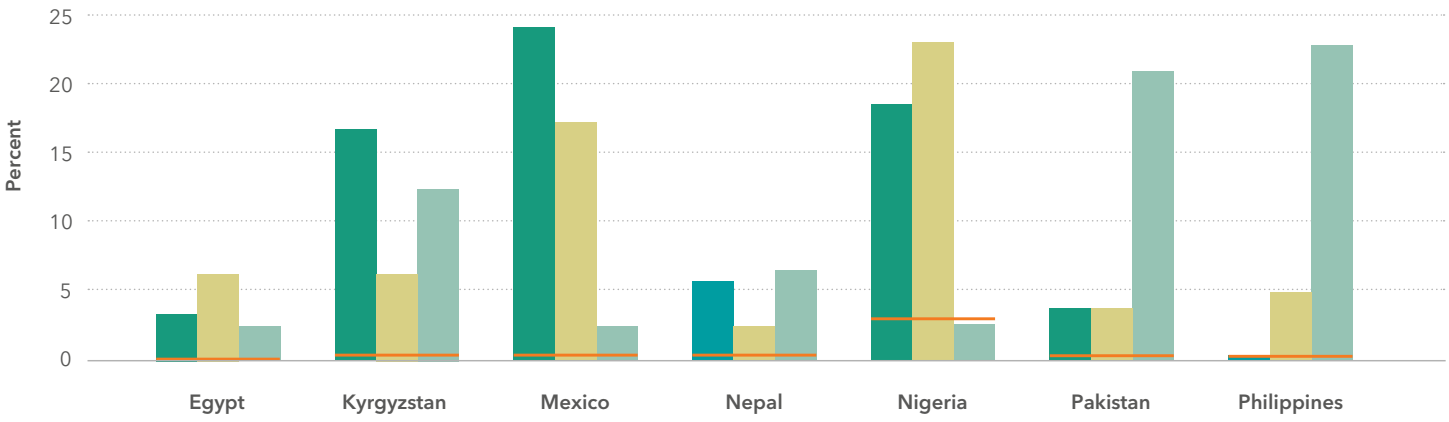

Source: UNAIDS. 2017. *Blind Spot: Reaching out to men and boys*. Retrieved from: http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf

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Partnerships Between FBOs, PEPFAR, and UNAIDS

UNAIDS and PEPFAR's existing partnerships with FBOs have supported increased access to care for members of key populations and stronger engagement with community leaders to address stigma and discrimination. Some of the current partnerships and programs are highlighted here:

1. *Expand understanding of current knowledge and attitudes towards key populations*
   Saint Paul's University, a member of the academic consortium working on the UNAIDS/PEPFAR Faith Initiative, conducted interviews and focus group discussions in Kenya to better understand the influence of religion on stigma and how faith-based health systems can minimize stigma and maximize support for members of key populations living with HIV and AIDS. Findings from this research will inform a curriculum to train FBOs and religious leaders on models of HIV care and support programs that reflect the needs and priorities of key population communities. The Christian Health Association of Kenya (CHAK), in partnership with Emory University's Interfaith Health Program, administered a survey to clinical providers at their HIV clinical sites to assess providers' knowledge and skills in providing high quality clinical care to key populations in CHAK faith-based facilities. Understanding current attitudes and knowledge as well as the influence of religion on stigma is an important first step to addressing and minimizing the stigma and discrimination that many key populations face.

2. *Engage and mobilize faith and community leaders*
   A commitment to address stigma and discrimination has motivated partners such as the World Council of Churches—Ecumenical Advocacy Alliance (WCC-EAA) to implement stigma reduction activities through direct engagement of religious leaders. Over 1,000 faith leaders around the world promoted HIV testing in their faith communities as a way to challenge the stigma that often accompanies HIV testing. WCC-EAA collaborated with UNAIDS Kenya, the Kenya chapter of the International Network of Religious Leaders Living With or Affected by HIV/AIDS (KENERELA+), and the Men Engage Kenya Network (MenKen) to use Framework for Dialogue meetings for a joint HIV mobilization campaign to sensitize and mobilize male faith and community leaders. These campaigns harnessed the clout of religious and traditional leaders to encourage uptake of HIV services among men. In Zambia, the World Council of Churches—Ecumenical HIV and AIDS Initiatives and Advocacy (WCC-EHAIA) worked with Trans Bantu Zambia, a national LGBT advocacy organization, to help implement a Contextual Bible Study program and establish a safe spaces initiative. The Contextual Bible Study model re-examines religious texts that have been used to justify violence and discrimination toward members of key population communities by listening to the concerns and points of view of people from those communities.

3. *Develop partnerships and collaborations to provide HIV care services*
   In Kenya, CHAK conducted an assessment of its HIV clinical providers on the clinical knowledge and skills that demonstrate best practices for working with key populations. This assessment is guiding ongoing clinical training and education. INERELA+ has developed a "SAVE" approach to HIV prevention that offers an alternative to dominant faith-based HIV prevention strategies. The SAVE approach provides comprehensive information in contrast to many faith-based programs that emphasize abstinence and fidelity alone.[3] The SAVE approach provides a more holistic way of preventing HIV as well as providing additional information about HIV transmission, prevention, providing support and care for those already infected, and actively challenging the denial, stigma, and discrimination commonly associated with HIV.[4] These inter-religious partnerships are essential to maximize limited resources and services from FBOs.

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