AIDS 2016 – Monday!

Highlights and insights from the EHPSA team

Sessions on **clinical care for MSM and LGBTI** provided living proof that it is possible to train healthcare workers to deliver sensitive and competent health services, even in countries where homosexuality is criminalised. GALZ's Caroline Maposhere described how she runs sessions in Zimbabwe – starting with a discussion on stereotyping. She encourages participants to speak about stereotyping of twins and left-handers before moving onto the more thorny issues of gender identity. To demonstrate the pain of stigmatising behaviour she does the "paper crushing" exercise. Once crushed into a tiny ball the sheet of paper is opened out and no matter how hard she tries, she can't erase the crease lines. "You can say sorry," she says, "but the damage is permanent."…

Here in South Africa, where gender diversity is protected by law, Anova's Health4Men programme has trained staff of over 250 of the state sector's primary care clinics in MSM sensitivity and competence. SANAC presented the draft South African National LGBTI Framework which proposes, among other things, to make PrEP available to MSM and other key populations. The plan will be finalised and launched within the next few weeks…

A sub-set of MSM, the transgender group is a deeply traumatised population who face severe stigma and discrimination. Incidence and prevalence of HIV in this group is disproportionately high, and access to health services remains a severe challenge. In Thailand, disaggregated routine data for this group is really helping to understand needs and system responses. This data also informs and gains the interest of policymakers. Medical education needs to include both clinical modules for dealing with the specific needs of this group and to break down stereotypes. Currently there is very little research and even talk of programming for transgender individuals living in African countries. I remain hopeful that with the resource commitments from PEPFAR and the Global Fund, together with the momentum built from AIDS 2016, the needs of transgender groups in Africa will be better prioritised and addressed…

Effective HIV prevention for key populations is hampered by several obstacles, stigma and discrimination being notable ones**. But what about HIV prevention for MSM in conservative social settings?** What happens when homosexuality, prostitution and adultery are linked to HIV in all the wrong ways and being HIV positive has been linked to a punishment from God? It fuels stigma, discrimination and it fuel the epidemic. 18% of new infections in the Middle East happen in MSM and with only 17% treatment coverage, the goal of 90-90-90 seems unattainable. The wheels of change turn slowly, but they turn, one Iman at a time. Iman Mohammad Abou Zeid is an example of a game changer, indicating that Imans need

the the right scientific information about AIDS, and with a powerful following he is in a position to make a difference. Proudly holding a condom in his hand, he said "in my country it's impossible to find an Iman carrying a condom in his hand." He changed the tone of his message effortlessly when he handed the condom to a conference delegate and said that the role of religious leaders is to help protect people, not to stigmatize and violate rights.

And now moving on to adolescents…

Having a sign that says “Youth Friendly Services” does not mean that the service are in fact youth friendly. Linda-Gail Bekker put forward an argument for being as bold as possible when designing and implementing health services for adolescents: Be creative. Make it funky.

The Tutu Teen Truck - a brightly coloured mobile health centre - plays music, serves as a hotspot and efficiently provides a range of services to both positive and negative youth alike. Technology is important: without appropriate technology (which won’t bore the youth) effectiveness of social behaviour communication will be limited. Despite the exponential increase of new infections amongst girls and young women (particularly in sub-Saharan Africa), HIV has fallen off the agenda of most youth. It is simply no longer an issue. Preventing new infection requires innovations – ones which will excite and interest youth, and could possible in the long-run, contribute to the introduction of youth friendly services in general..

First Things First (HEAIDS) focuses on comprehensive health programmes for young people in the higher and secondary education sector. It takes comprehensive health approach – there is no difference in the number of sexual partners of young people on the previously disadvantaged and the previously advantaged campuses. Just as these statistics don’t differ, the approach to get young people to test for a range of health factors was the same - driven by peer educators. HIV, TB STI and other test uptake increased exponentially.

This session also provided an interesting and enlightening take on the ‘anatomy’ of the HIV epidemic in SA. Prof Q Abdool Karim argued that the data shows that we should think of the epidemic more as multiple localised epidemics with defining characteristics – for example although South Africa carries around 20% of the total HIV burden in the world this is not spread evenly across the country. For example 8 (out of 52) health districts have an HIV prevalence of more than 40% in comparison with others of under 20%. Another characteristic relates to young women generally acquiring HIV earlier than young men: approximately 8 years earlier than young men. Young women are infected between the ages of 15 and 18, and young men from 25 years onwards. Young women in those early years have male partners on average 8 years older. Thinking through this could mean that we see a tri-directional relationship of infection.

Take away from the session: focus on the local or regional characteristics of the epidemic, and through peer education and methods let young people focus looking after their health as opposed to only HIV.