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ISSUE BRIEF

The Shifting Global Health Landscape: Implications for HIV/AIDS and Vulnerable Populations

Introduction

A new chapter is unfolding in the global response to the HIV/AIDS epidemic. While the last decade has seen an unprecedented worldwide emphasis on scaling up disease-specific programs for HIV and other priority diseases, major donors are rapidly embracing a new paradigm that emphasizes service integration and the "mainstreaming" of HIV into broader health systems and programs. In the U.S., the trend is evidenced by the Obama Administration's emphasis on health systems strengthening over more "vertical" disease-specific programming, and on promoting greater ownership of health programming by country governments that receive external donor assistance to meet domestic health needs.

> Reaching vulnerable populations with effective HIV prevention and treatment services is a critical priority in the effort to bring the AIDS epidemic under control.

There are many good reasons for an increased focus on health systems strengthening. Efforts to bring essential HIV prevention and treatment services to scale have been impeded by systemic weaknesses in healthcare delivery in low- and middle-income countries.[1] Linking HIV services with other service systems—such as tuberculosis, malaria, or family planning—could potentially expedite service scale-up, reduce stigma, and simultaneously further progress toward multiple health aims. In addition, it is hoped that promoting government ownership of domestic health programming in low- and middle-income countries will encourage governments to be more responsive to the needs of their populations and make progress on health delivery more sustainable.

Yet these trends in global health funding raise concerns about the ability to meet the needs of many of the most vulnerable

Key Points

- Men who have sex with men (MSM), injecting drug users (IDUs), sex workers, and transgender individuals are among those groups at elevated risk for HIV/AIDS in both concentrated and generalized AIDS epidemics throughout the world.
- Addressing the health needs of vulnerable populations is critical to an effective and equitable response to the global AIDS epidemic.
- Vulnerable populations are very often not well served by health services designed to meet the needs of the general population.
- The behavior of MSM, IDUs, and sex workers is criminalized in many countries, and many governments ignore or are actively hostile towards these individuals.
- There are numerous examples of targeted services that can reach marginalized populations with effective HIV prevention and treatment services.
- Health worker training and other measures can make general health systems more responsive to the needs of vulnerable populations.
- Donors and policy makers should assess what types of services can best meet the needs of vulnerable, marginalized groups in each specific setting.
- Donors, policy makers, and advocates should press for policy reforms that reduce stigma and make it easier to meet the health needs of vulnerable populations.

populations affected by the HIV/AIDS epidemic, including men who have sex with men (MSM), injecting drug users (IDUs), and sex workers. The evidence indicates that many people in these populations have legitimate worries about accessing general health services, and may not receive quality, non-discriminatory services if they do. Furthermore, governments in many—if not most—countries criminalize the behavior of these groups, making it difficult for people to receive appropriate health services.

These realities are deeply concerning for people in vulnerable groups, but they also undermine the overall response to HIV/AIDS. Reaching vulnerable populations with effective HIV prevention and treatment services is a critical priority in the effort to bring the AIDS epidemic under control. In most countries HIV is a disease that discriminates, disproportionately affecting society's most vulnerable. Even in generalized epidemics in which a significant share of the general population is living with HIV/AIDS, people in the groups noted above very often have significantly higher rates of HIV infection.

This issue brief focuses on the challenge of delivering effective, high-quality, non-discriminatory services to vulnerable populations, with specific attention to the needs of MSM, sex workers, and IDUs. (There are, of course, numerous other populations that are particularly vulnerable to HIV, including transgender individuals, negative partners in HIV-discordant couples, and migrant workers.) The brief draws on a review of published literature and key informant interviews with leading researchers and implementers. It summarizes the epidemic's disproportionate impact on these populations, the programmatic and policy challenges these groups confront in accessing potentially life-saving HIV services, and the characteristics of programs that have proven successful in reaching key populations. Finally, the brief offers recommendations regarding ways to approach HIV mainstreaming and service integration that would best protect the interests of the groups most at risk of HIV.

Figure 1

Estimated HIV Prevalence at a Glance

Adults worldwide	0.4%
Men who have sex with men	6%
Sex workers	3%
Injecting drug users	13%

Sources: WHO et al., 2009; U.S. Census Bureau, 2010; UNAIDS, 2008.

Vulnerable Populations at the Center of the HIV/AIDS Pandemic

As Figure 1 illustrates, MSM, sex workers, and IDUs have estimated HIV prevalence rates that are significantly higher than that of the general population. As the discussion below reveals, global estimates of HIV prevalence significantly understate the extent of infection in diverse localized settings.

It has long been known that sex workers in all regions confront elevated risk of HIV infection. In 2008, for example, a blue-ribbon panel, the Commission on AIDS in Asia and the Pacific, reported that transmission during sex work was a critical determinant in the trajectory of the epidemic.[2]

While it was long believed that transmission among MSM and IDUs was primarily a priority in concentrated epidemics outside sub-Saharan Africa, recent studies have found that these groups represent a considerable percentage of new HIV infections in many African countries.

> According to a meta-analysis of relevant studies, 28% of transgender people in the U.S. are estimated to be HIV-infected.

Nearly three decades into the epidemic, it is clear that MSM, people who inject drugs, and sex workers are at greater risk of contracting HIV in virtually every part of the world. These groups represent roughly one-third of all new infections in Kenya[3] and nearly one in four in Nigeria, Africa's most populous country.[4]

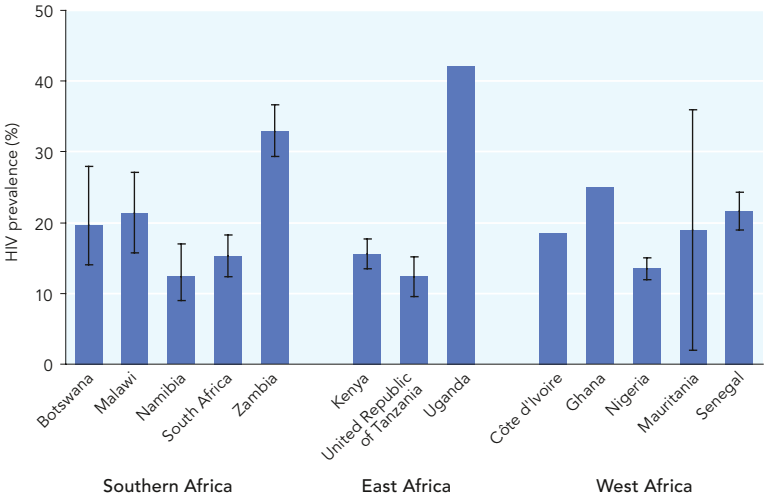
Men who have sex with men

In a number of high- and middle-income countries, MSM represent the majority of new HIV infections. This is especially true in North America, Latin America, parts of Western Europe, Australia, and New Zealand.[5]

Recent studies have documented extremely high HIV prevalence among MSM in other regions. As Figure 2 illustrates, exceptionally high prevalence has been documented among MSM in several African countries[5] with particularly high infection rates among gay-identified men.[6] Likewise in Asia, researchers estimate that MSM confront nearly one-in-five odds (18.7%) of being infected with HIV.[7] In countries where HIV prevalence among MSM was believed to be low, infection rates appear to be on the rise. Annual surveys in Beijing have identified a clear upward trend in HIV prevalence among MSM.[8] In parts of West Africa, recent epidemiological analyses sug-

Figure 2

HIV prevalence among men who have sex with men in countries in sub-Saharan Africa, 2000–2008



Source: Smith et al. (2009) and Baral (2009).

gest that MSM account for up to 20% of incident infections in some countries.[9]

Indeed, surveys have consistently found HIV infection levels among MSM that far exceed those in the general male population. In Thailand, an estimated 24.6% of MSM are living with HIV, compared to 1.6% of the adult population. Other countries display similar patterns: Senegal (21.5% vs. 1.0%); Colombia (19.4% vs. 0.7%); Uruguay (18.9% vs. 0.6%); Honduras (13.0% vs. 1.7%); Kenya (10.6% vs. 6.9%); Sudan (9.3% vs. 1.7%); and Cambodia (7.8% vs. 1.8%).[7] In sub-Saharan Africa, it is estimated that MSM are 4–5 times more likely to be infected than other males.[10]

Transgender communities also experience considerable HIV-related vulnerabilities. In one study in southern India, HIV prevalence among male-to-female transgender people (*hijras*) was 18.1%.[11] According to a meta-analysis of relevant studies, 28% of transgender people in the U.S. are estimated to be HIV postive.[12]

People who inject drugs

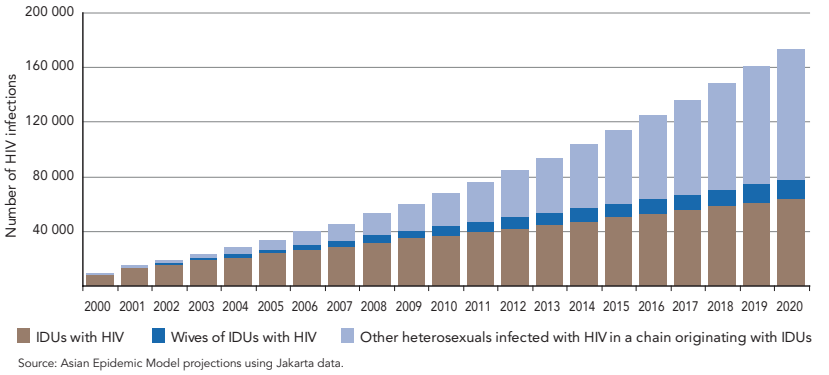
Globally, an estimated 16 million people inject drugs.[13] People who inject drugs are believed to constitute up to one-third of new HIV infections outside sub-Saharan Africa.[14] Use of contaminated equipment during injecting drug use accounts for a majority of new infections in Eastern Europe and Central Asia—the one region where infection rates are clearly on the rise[5]—and there is evidence that sexual transmission is on the rise among the partners of HIV-infected drug users.[15,16]

Due to the ease of transmissibility during subcutaneous exposure to HIV and the often closed social networks of drug users, HIV can spread rapidly once it enters an urban community of drug users. In many countries, transmission rates among drug users will largely determine the future of national epidemics. For example, a doubling in annual HIV incidence is projected in Jakarta, Indonesia, with virtually all of the anticipated growth stemming either directly or indirectly from transmission during injecting drug use (see Figure 3).[5]

Recent studies have refuted the notion that transmission during injecting drug use is not a major factor in Africa's epidemic. An estimated 221,000 people who inject drugs are estimated to be living with HIV in sub-Saharan Africa.[13] Setting-specific surveys of drug users in Africa have detected exceptionally high HIV prevalence, ranging from 12.4% of drug users in South Africa to 42.9% in Kenya.[13] A recent global meeting of drug policy leaders focused on the disturbing trend of increasing heroin use in sub-Saharan Africa, which suggests potential increases in drug-related HIV transmission.[17] In Ghana, evidence suggests an annual HIV incidence of 4% among people who inject drugs.[18]

Figure 3

Projected total number of HIV infections in various population groups, 2000–2020, in Jakarta, Indonesia



Source: Asian Epidemic Model projections using Jakarta data.

Sex workers

The number of female sex workers varies considerably by region, and extant surveys may not account for all informal, non-monetary exchanges for sex.[19] Men also participate in sex work in virtually all countries, although data are more plentiful on female sex workers, who are believed to outnumber

their male counterparts. As the world becomes increasingly globalized, research indicates that both opportunities and demand for sex work are expanding.[20]

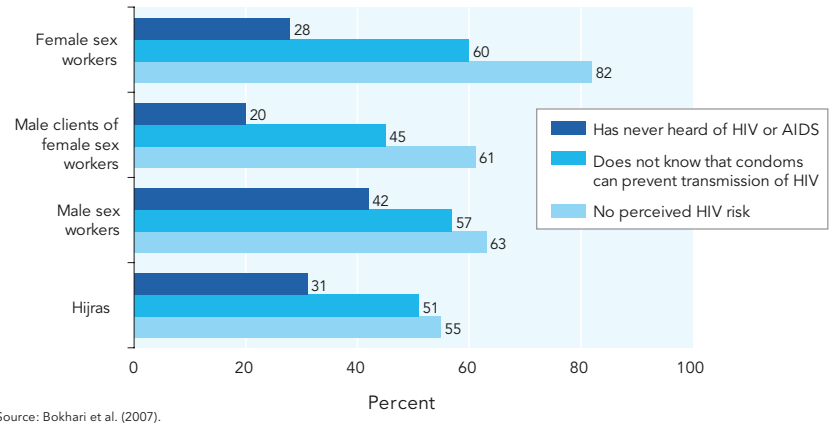
Significant HIV outbreaks among urban networks of sex workers have been reported throughout Eastern Europe and Central Asia.[21] In sub-Saharan Africa, roughly one in four sex workers is estimated to be HIV positive[22]—a prevalence level four times higher than that of the adult African population.[1] Comparable infection levels have been reported among sex workers in Asia.[5]

Injecting drug use among sex workers is common in many countries,[21] further increasing their risk for HIV. Many sex workers are also migrants,[21,23] placing them in situations of heightened vulnerability and potentially reducing their access to mainstream health services.

Sex workers have an acute need for HIV prevention and other health services. According to surveys conducted in Pakistan, more than 80% of sex workers do not perceive themselves to be at risk for HIV, 60% do not know that condoms reduce the risk of transmission, and more than one in four has never even heard of AIDS (see Figure 4).[24]

Figure 4

Vulnerability to sexual HIV transmission in commercial sex in Karachi and Lahore, Pakistan



Source: Bokhari et al. (2007).

Official Neglect of the Health Needs of Vulnerable Populations

Evidence to date suggests that mainstream health systems may not currently be capable of delivering essential HIV services to MSM, IDUs, and sex workers in many high-incidence settings. Despite the unparalleled vulnerability of these groups to HIV, national governments and international donors have routinely shortchanged most-at-risk populations, preferring to allocate scarce funding toward programs targeting low-risk individuals.

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Limited or inaccessible services

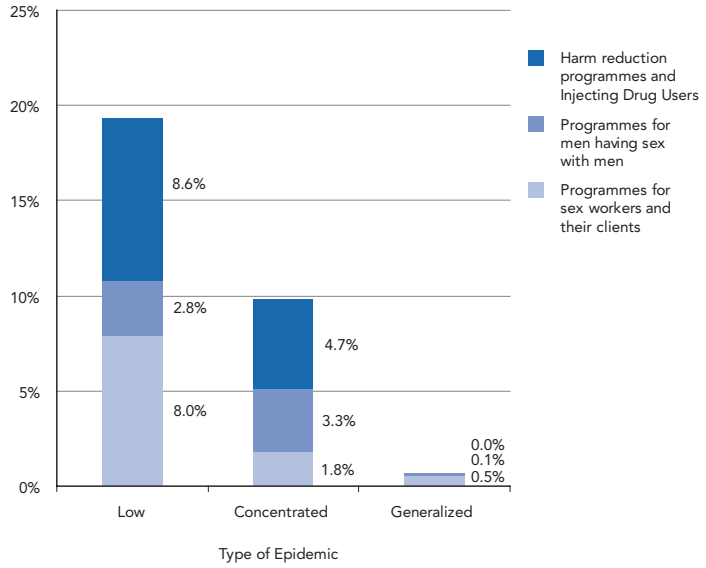
Although vulnerable populations have infection rates that are many times higher than other groups, they are often last in line for HIV funding. As Figure 5 reveals, prevention funding for these populations is minimal even in low-level and concentrated epidemics, where infections are heavily clustered among vulnerable populations. In low-level epidemics, less than 20% of prevention spending is allocated to programs targeting most-at-risk populations, and in concentrated epidemics, only 10%.[1] The skewed HIV priorities of many countries with concentrated epidemics are vividly illustrated in Figure 6, which compares HIV prevention spending for programs targeting MSM with the disease burden shouldered by MSM in Latin America.

What is true for MSM is true for other key populations. Globally, the amount of resources allocated for harm reduction programs for drug users is so low that total funding amounts to about 3¢ per day for each person who injects drugs.[25]

As revealed by Figure 5, prevention spending on most-at-risk populations is virtually nonexistent in high-prevalence countries. This is true even for sex workers in Africa, who have long been shown by studies to experience elevated risk of infection. According to a recent epidemiological exercise in Ghana, sex workers, their clients, and the partners of sex work clients accounted for roughly one in three new infections.[18] Even when health services are theoretically available, many clients are denied access due to bureaucratic rules. In many

Figure 5

Spending in programmes specifically directed to the populations most at risk for HIV as a percentage of total prevention spending by type of epidemic—public and international funds, 2006



Source: UNGASS Country Progress Reports, 2008

Eastern European and Central Asian countries, for example, access to health services is conditional on proof of identity as a citizen, yet many sex workers lack such documentation because they are migrants.[21]

The number of sterile syringes distributed annually to each injecting drug user in Latin America and the Caribbean is 0.3; in the Middle East and North Africa, 0.5; and in sub-Saharan Africa, 0.1.

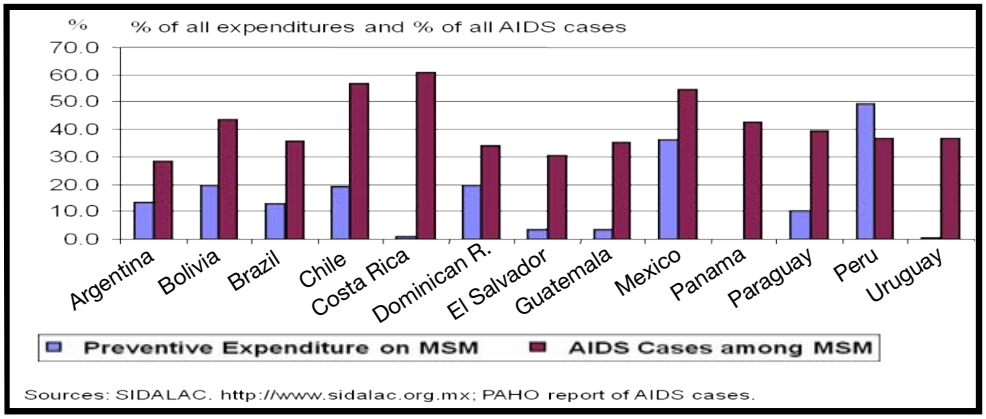
The end result of meager investments and bureaucratic obstacles is extraordinarily low coverage levels for HIV prevention and treatment services for the populations most heavily affected by the epidemic. In a recent 14-country study, fewer than 4% of people who inject drugs had access to medication-assisted treatment with either methadone or buprenorphine.[26] In Chile, Kenya, Pakistan, Russia, and Uzbekistan, fewer than one in 100 HIV-positive injecting drug users are receiving antiretroviral therapy.[27] The number of sterile syringes distributed annually to each injecting drug user in Latin America and the Caribbean is 0.3; in the Middle East and North Africa, 0.5; and in sub-Saharan Africa, 0.1.[27]

The impact of stigma and discrimination in healthcare and other settings

Healthcare personnel live and work within broader societies and are often influenced by prevailing social norms and prejudices. In places where society at large regards most-at-risk populations as expendable—or, even worse, as groups that need to be actively eradicated—there is a genuine risk that health workers will share some of those prejudices. As nongovernmental informants reported in 2010 as part of the formal process of monitoring progress on agreed core AIDS indicators, "Most health workers bring their values and beliefs to the workplace; they don't offer health services to all who present with ailments but they judge the clients."[28] Where a climate of fear, hostility, and social exclusion exists, members of key populations may naturally fear seeking services from mainstream health systems.

- **MSM:** Anti-gay and anti-transgender attitudes are common throughout the world. At least 85% of Africans routinely tell pollsters that homosexuality is unacceptable.[10] Anti-gay violence is commonplace in Jamaica, where protesters celebrated the murder of the country's leading gay rights activist in 2004.[29] According to amfAR-supported research by Dr. Theodorus Sandfort and colleagues at the Research Foundation for Mental Hygiene, black MSM in or near Pretoria, South Africa, reported higher levels of internal stress related to their same-sex sexuality than white MSM in the area. Prevalent social hostility toward MSM is manifest in the actions of healthcare workers. In Swaziland, nongovernmental informants report that "men having sex with men are not welcome in public health facilities [as] they are first to report to the police if they present with anal infections."[28] A 2009 survey of MSM in Botswana, Malawi,

Figure 6



and Namibia found that 42% of men had experienced at least one instance of human rights abuse, such as blackmail or denial of housing or healthcare.[30] A study commissioned by the International HIV/AIDS Alliance in India determined that MSM routinely confront "misunderstanding and misconceptions about same-sex sexuality among the general public and healthcare providers."[31]

- **People who inject drugs:** Throughout the world, drug users are regarded as "undesirable," with their addiction attributed to character weakness or moral failings.[32] The so-called "war on drugs" waged by many countries too often amounts to a war on drug users. As the Latin American Commission on Drugs and Democracy found, societal attitudes toward drug use are typically founded on prejudice and fear, resulting in criminal laws segregating drug users in closed communities where they are made more vulnerable to violence and organized crime.[33] Among healthcare workers, disapproving attitudes toward drug users are exacerbated by the widespread sentiment that drug-using patients are difficult and more time-consuming than other patients.[34]

- **Sex workers:** A wealth of research has documented the extraordinary stigma, social marginalization, and discrimination faced by sex workers throughout the world.[21,23,35,36,37] Ethnographic studies of sex workers in Africa have found that many women are ostracized by their family and typically live from hand to mouth.[23] Many health programs treat sex workers as "fallen women," adopting disapproving or paternalistic approaches that inevitably deter service participation.[38] As one indicator of their low social status, sex workers are frequently at extremely high risk of violence from pimps, clients, or law enforcement personnel.[21] In some countries, the media has played a notable role in fanning the flames of stigma toward sex workers, often abridging workers' rights to privacy and confidentiality by publishing their pictures and revealing their identities without consent.[21] Even in countries where public health authorities have adopted more enlightened approaches to addressing their HIV-related needs, social disapproval of sex workers persists and can undermine the impact of public health programs.[35]

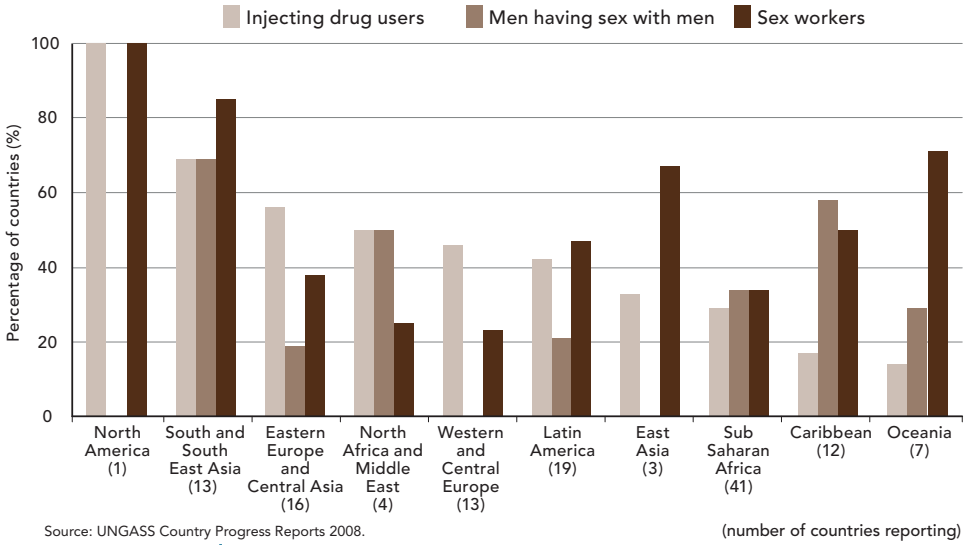
The likelihood of experiencing negative social attitudes in mainstream health settings often leads people at high risk of infection to avoid services.[39] A survey of more than 1,000 civil society representatives by the nongovernmental delegation to the UNAIDS Programme Coordinating Board found that 56% had experienced negative attitudes because of their association with certain groups and that 42% had encountered health workers who were not helpful or willing to provide care; among the roughly one-quarter of participants who said they were afraid to access services, 53% said they were fearful that health workers would refuse to provide care.[66]

> Not only do stigmatizing attitudes among health workers deter many individuals from seeking the health services they need, they also diminish the quality of services for those who access them.

In a study of 285 MSM in Johannesburg and Durban, South Africa, that detected an HIV prevalence rate of 43%, only 6.8% of study participants expressed a preference for receiving HIV prevention services from a government clinic. According to the researchers who conducted the study, "Mainstream public sector health services are inadequate and tend to be insensitive and unresponsive to the needs of MSM."[40] These findings are similar to those resulting from an

Figure 7

Percentage of countries reporting laws, regulations or policies that present obstacles to effective HIV services for most-at-risk populations



Source: UNGASS Country Progress Reports 2008.

amfAR-supported study by Dr Waimar Tun of the Population Council, which found that 40% of MSM surveyed in South Africa said they would not be comfortable receiving HIV testing services in a government clinic.

Unequal access to HIV-related medical services is especially well documented with respect to people who inject drugs. HIV-positive drug users are significantly less likely than other groups to receive antiretroviral drugs, even in settings where local epidemics are largely driven by drug-related transmission.[41,42,43] In Eastern Europe and Central Asia, where in 2004 people who inject drugs accounted for more than 80% of reported HIV cases, they represented less than one in four (24%) patients on antiretroviral therapy.[44] A more recent survey in Latvia, a country where the majority of people living with HIV are drug users, IDUs accounted for less than a third of people on antiretroviral therapy.[45]

Not only do stigmatizing attitudes among health workers deter many individuals from seeking the health services they need, they also diminish the quality of services for those who access them even in the face of negative attitudes. With respect to MSM, for example, the World Health Organization (WHO) recommends that health services should be "delivered within a framework of sexual health, which includes discussions of relationships, self-esteem, body image, sexual behaviors and practices, spirituality, sexual satisfaction and pleasure, sexual functioning and dysfunction, stigma, discrimination, and alcohol and drug use."[46] Needless to say, health workers who believe that homosexuality is a "curse" or an immoral aberration are unlikely to deliver services in the manner recommended by WHO.

The prevalence of negative attitudes toward most-at-risk populations undermines the very basis of a strong provider-patient relationship. According to a survey of sex workers in San Francisco, most had never discussed their work with a medical provider.[47]

Governments' treatment of vulnerable populations and its impact on health services

Many governments enshrine prevailing hostility toward most-at-risk groups into law, effectively institutionalizing the exclusionary effects of social attitudes. As Figure 7 reveals, a large percentage of countries have laws or regulations that impede the delivery of services to individuals who need them. Some of these patterns are especially revealing. In Eastern Europe and Central Asia, where epidemics are primarily driven by transmission during drug use, nearly 60% of countries report having laws that limit drug users' access to HIV services. Although sex work is a primary driver of epidemics in Asia, more than 80% of countries in South and Southeast Asia have adopted legal frameworks that interfere with sex workers' access to services. And although infections among MSM in Asia and the Caribbean are on the rise, roughly 60% of countries in these regions have discriminatory laws in place regarding MSM.

- **MSM:** Seventy-six countries around the world—most of them developing countries—criminalize homosexual conduct.[48] In many countries, criminal penalties for homosexual behavior are extremely severe, including four countries that permit the death penalty to be imposed.[10] A major step forward in the fight for human rights for MSM occurred in 2009 when the Delhi High Court invalidated India's long-standing prohibition on same-sex sexual contact, effectively freeing one-sixth of the world's population from anti-gay legislation.[48]

- **People who inject drugs:** The use, sale, or possession of illicit drugs is routinely criminalized. Many countries require drug users to be registered before they are eligible for drug treatment services, an approach that invites violations of civil rights and inevitably drives many away from services.[26,49] National laws also restrict access to key harm reduction services; currently, methadone maintenance substitution therapy is allowed in only 62 countries (including several that only allow pilot programs), while buprenorphine substitution therapy is available in only 35 countries.[50] More than 50 countries worldwide mandate coercive or compulsory treatment for individuals convicted of a drug offense,[51] creating extraordinarily harsh and onerous conditions in many settings.[32,52] These coercive legal frameworks cause many drug users to actively avoid health services.[53]

- **Sex workers:** Offering or soliciting sex in exchange for money is illegal in at least 110 countries.[51] Even where laws do not expressly criminalize sex work, legal practices nevertheless restrict the right to organize, advertise, or profit from sex work.[21] In particular, law enforcement personnel routinely harass sex workers in many countries.[21]

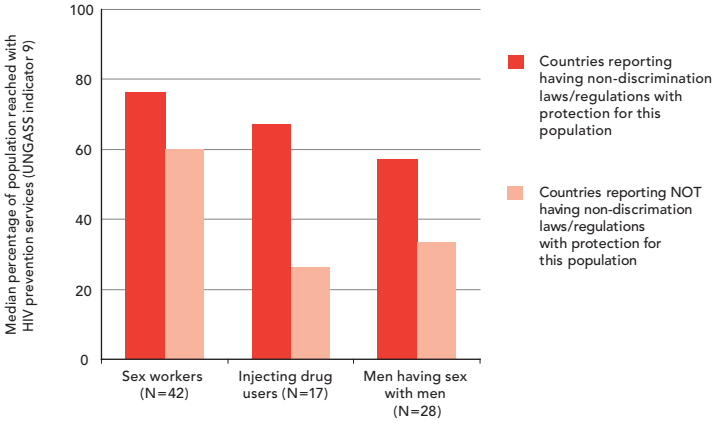
These stigmatizing legal frameworks do more than reinforce existing prejudices; they also result in concrete reductions in service utilization among populations targeted by these laws. As Figure 8 reveals, service coverage for most-at-risk populations is considerably higher in countries where nondiscrimination laws or regulations are in place.

Effective Strategies to Reach Vulnerable Populations

In the wake of the failure of mainstream service systems to deliver for vulnerable populations, more targeted strategies have been successfully used to provide essential services to MSM, IDUs, and sex workers. The success of these strategies in overcoming systemic impediments provides potential guidance on future approaches to ensuring meaningful access for most-at-risk populations.

Figure 8

Median percentage of population reached with HIV prevention services within the specified legal environment



Source: UNGASS Country Progress Reports 2008.*

* Between one third and a half of the countries did not provide information on non-discrimination laws/regulations for most-at-risk populations. Information from NCPI: a different data set (from different countries) from that reflected in Figure 4.10.

Creating community-tailored service options

With so many people from marginalized communities deterred from seeking services from mainstream channels, resourceful community activists, program implementers, and public health leaders have instead developed alternative service options that are specifically tailored to the needs of individual populations. Harm reduction programs offer a classic example. While these programs may sometimes serve as bridges to mainstream services, such as medication-assisted treatment programs, they are most likely to be situated not in a public clinic but rather in settings that are conveniently located and designed to appeal to community members.

Indeed, innovation and community focus have defined the field of harm reduction services. For example, an outreach and syringe exchange program specifically tailored to the needs of individuals along the China-Vietnam border was found to have resulted in a substantial reduction in new HIV infections.[54] In Russia, community leadership has been central to the highly successful, Global Fund-supported GLOBUS project, which has expanded harm reduction services, successfully fought to lower antiretroviral drug prices in the country, and worked to reduce stigma and discrimination against drug users living with HIV.[55]

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In Abidjan, Côte d'Ivoire, the Espace Confiance clinic reflects the special care taken to develop unique service options for populations that might otherwise lack access through mainstream channels. Established in 1992 to serve female sex workers, the clinic expanded its services in 2004 to address the growing health needs of MSM. Specifically responding to the lack of accessible, non-discriminatory health services in many mainstream settings, the clinic provides behavior change communication, HIV testing and counseling, STI screening and treatment, primary healthcare, and HIV prevention information and supplies. As of April 2010, approximately 1,000 patients were receiving services at the clinic, including 500 on antiretroviral therapy.[56]

Founded in 2002, the Avahan India AIDS Initiative demonstrates the potential of tailored service options to increase service access for marginalized communities. With programming concentrated in high-prevalence states, Avahan undertook mapping of target populations (e.g., injecting drug users, female sex workers, and MSM) and worked with community members and local NGOs to develop service channels that were expressly designed to reach these key populations. As Figure 9 reveals, the results have been remarkable, with coverage approaching universal access to populations long considered difficult or impossible to reach.

Building social capital

Social bonding within key populations has repeatedly proven to provide the most effective foundation for reaching individuals with essential health services. This approach builds on existing social networks, incorporates advocacy for human rights and service access as essential strategic components, and involves peer-led efforts to strengthen social solidarity in order to reduce risk to the community.

Perhaps the most powerful documentation of this approach has concerned networks of sex workers in different parts of the world. One of the world's prevention successes

remains the Sonagachi Project in Calcutta, India, which used multi-faceted, multi-level interventions grounded in a community empowerment approach to achieve remarkable health outcomes for local sex worker networks.[38] Community empowerment approaches have also proven effective in reducing HIV risk for sex workers in the Dominican Republic.[57] In a survey of 420 sex workers in Corumbia, Brazil, increased social cohesion and participation in social networks correlated with a lower number of unprotected sex acts.[58]

Similarly, social cohesion has played a vital role in creating essential services for MSM and people who use drugs. The long history of AIDS solidarity in gay communities in high-income countries has been well documented.[59] Grassroots efforts, which are at the heart of vibrant, emerging responses of MSM communities,[60,61] are addressing the HIV-related needs of MSM throughout the world. These efforts include a new community network for sexual minorities that recently conducted a needs assessment of MSM in Lesotho.[62]

The Way Forward: Recommendations for Action

In light of the enormous barriers to effective service provision for vulnerable populations through mainstream service systems, amfAR offers the following recommendations to guide action:

- **Increase investments and support for service channels specifically designed for vulnerable populations**

  Given the lack of readiness of mainstream service systems to provide respectful, nonjudgmental, high-quality services to MSM, people who inject drugs, and sex workers, the push toward universal access to HIV services demands stronger and sustained investments in services designed for these groups. Program planners and implementers should meaningfully involve affected communities from the outset in planning service options.

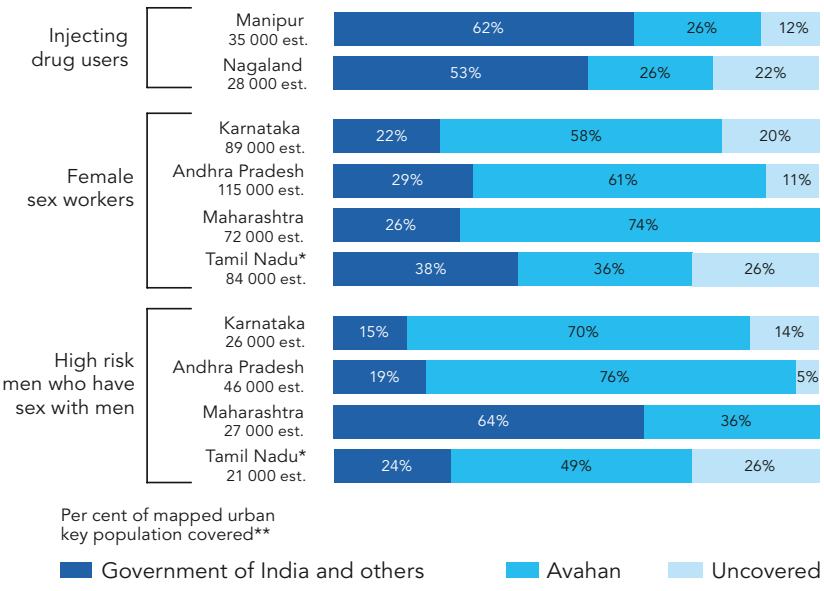
  Some potentially promising moves in this direction have been announced recently by major funders. The Global Fund to Fight AIDS, Tuberculosis and Malaria, in launching its tenth funding round, has set aside US$200 million to fund programs for most-at-risk populations in concentrated epidemics. This special fund will not compete with funding for low-income countries. Although the amount is modest and does not address the need for tailored programs in high-prevalence settings, it nevertheless is a step in the right direction. Similarly, the President's Emergency Plan for AIDS Relief (PEPFAR) has recently pledged in its new five-year strategy to emphasize "targeting interventions to most-at-risk populations with high incidence rates."[63]

- **Build capacity of health systems to address needs of vulnerable populations**

  While increasing investments in specific service channels expressly designed for most-at-risk populations, national governments, international donors, and technical agencies should embark on a long-term process to build the capacity of health systems to provide appropriate services for key populations. Through a combination of training, mandates, and regulations, health systems should begin the process of de-mystifying service provision for marginalized populations by educating providers about their specific health and sexual health needs, alleviating health

Figure 9

Saturating prevention coverage through complementary programming. Avahan has achieved a high coverage of target populations (routine programme monitoring data)



Percentages indicate intended coverage through establishment of services in specific geographic areas.
* Includes districts with no intended coverage.
** Mapping and size estimation quality varies by state.
Does not include rural areas

Source: Avahan and State AIDS Control Society programme data (2008).

workers' prejudices, dispelling myths and misconceptions, and putting in place rules that require that all patients receive fair and equal treatment.

A number of capacity-building strategies have emerged to take on this challenge. For example, in 2009, the Desmond Tutu HIV Foundation released a comprehensive training manual designed to build the cultural competence and technical skills of health workers to address the diverse health needs of MSM in Africa.[10] Similarly, the International HIV/AIDS Alliance launched a guide for facilitators of consultations to increase service providers' capacity to respond to the HIV-related needs of MSM in Africa.[64] In Latin America and the Caribbean, the Pan-American Health Organization convened a 2009 consultation on the healthcare needs of MSM, which resulted in the launch of a blueprint for comprehensive care for MSM.[65]

Ultimately, the most effective long-term strategy for ensuring appropriate care for marginalized populations is to alter the prejudicial and discriminatory attitudes that influence health workers and the systems in which they work.

- **Determine the right mix between NGO and government providers**

  External donors have a critical responsibility to assess the degree to which government-run health facilities will be able to meet the needs of marginalized and highly vulnerable populations. In some cases, non-governmental organizations will be better positioned than government agencies to deliver services to vulnerable groups. In others, clients may prefer to obtain services from government-run centers.

  Because vulnerable populations are highly diverse, the optimal approach will be to ensure a robust mix of services that include non-discriminatory, culturally appropriate services operated by the government, as well as tailored services conceptualized and delivered by communities themselves. This approach will require extensive capacity-building efforts. Government workers will need increased capacity to understand how to reach key populations and to serve them appropriately, while community organizations will need substantial new resources, managerial expertise, and help with organizational development. In undertaking this dual capacity-building endeavor, it will be critical to recognize and address the challenges that may be associated with a mutually productive co-existence of government- and community-run programs, especially in settings where target populations remain highly stigmatized.

- **Promote social change and implement legal reforms**

  Ultimately, the most effective long-term strategy for ensuring appropriate care for marginalized populations is to alter the prejudicial and discriminatory attitudes that influence health workers and the systems in which they work. Laws should be revised to prohibit discrimination on the basis of membership in a marginalized group. Specifically, countries should repeal all laws that criminalize same-sex sexual behavior, as well as the sale or purchase of sex, taking steps to ensure meaningful economic opportunities for people who do not desire to enter sex work.

  Public policy should also adopt a public health and rights-based approach to drug use, investing in drug treatment rather than incarceration. Laws restricting access to essential health services for drug users and others should be removed; laws affirming the human rights of vulnerable populations are needed.

  Public education campaigns should be initiated to change social norms and attitudes regarding MSM, drug users, and sex workers. These should be supported by school-based programs that work to produce future generations that are more tolerant and accepting of difference.

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REFERENCES

1. UNAIDS (2008). *Report on the global AIDS epidemic*. Geneva.
2 Commission on AIDS in Asia and the Pacific (2008). *Redefining AIDS in Asia: Crafting an Effective Response*. New Delhi: Oxford University Press.
3 Gelmon L et al. (2009). Kenya: HIV prevention response and modes of transmission analysis. Nairobi: Kenya National AIDS Control Council.
4 National Agency for the Control of AIDS (2010). *United Nations General Assembly Special Session (UNGASS) Progress Report – Nigeria*. Available at: http://data.unaids.org/pub/Report/2010/nigeria_2010_country_progress_report_en.pdf. Accessed on May 26, 2010.
5 UNAIDS (2009). *AIDS epidemic update*. Geneva.
6 Lane T et al. (2009). High HIV Prevalence Among Men Who have Sex with Men in Soweto, South Africa: results from the Soweto Men's Study. *AIDS Behavior* doi:10.1007/s10461-009-9598-y.
7 Baral S et al. (2007). Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: a systematic review. *PLoS Med* 4(12):e339.
8 Ma X et al. (2007). Trends in prevalence of HIV, syphilis, hepatitis C, hepatitis B, and sexual risk behavior among men who have sex with men: results of 3 consecutive respondent-driven sampling surveys in Beijing, 2004-2006. *JAIDS* 45(5):581-587.
9 Lowndes CM et al. (2008). *West Africa HIV/AIDS epidemiology and response synthesis: implications for prevention*. Washington, D.C.: World Bank.
10 Desmond Tutu HIV Foundation et al. (2009). *Men who have sex with Men: An Introductory Guide for Health Workers in Africa*.
11 Brahman GNV et al. (2008). Sexual practices, HIV and sexually transmitted infections among self-identified men who have sex with men in four high HIV prevalence states in India. *AIDS* 22 (Supp. 5):S45-S57.
12 Herbst JH et al. (2008). Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review. *AIDS and Behavior* 12:1-7.
13 Mathers BM et al. (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet* 372:1733-1745.
14 UNAIDS (2006). *Report on the global AIDS epidemic*. Geneva.
15 Van de Laar MJ et al. (2008). HIV/AIDS surveillance in Europe: update 2007. *Eurosurveillance* 13(50):pii=19066.
16 Des Jarlais DC et al. (2009). HIV among injecting drug users: current epidemiology, biologic markers, respondent-driven sampling, and supervised-injection facilities. *Current Opinions in HIV and AIDS* 4:308-313.
17 Agence France Presse (2010). *Drug abuse imperils African advances against AIDS spread: experts*. May 24. Available at: http://news.yahoo.com/s/afp/20100524/hl_afp/africacrimedrugshealthaids. Accessed on May 26, 2010.
18 Bosu WK et al. (2009). *Modes of HIV transmission in West Africa: analysis of the distribution of new HIV infections in Ghana and recommendations for prevention*.
19 Vandepitte J et al. (2006). Estimates of the number of female sex workers in different regions of the world. *Sex Transm Infect* 82:iii18-iii25.
20 Ward H, Aral SO (2006). Globalisation, the sex industry, and health. *Sex Transm Infect* 82:345-347.
21 Central and Eastern European Harm Reduction Network (2005). *Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia*.
22 WHO, UNICEF, UNAIDS (2009). *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*.
23 Campbell C (2003). *Letting Them Die: Why HIV/AIDS Prevention Programmes Fail*. Bloomington: Indiana University Press.
24 Bokhari A et al. (2007). HIV risk in Karachi and Lahore, Pakistan: an emerging epidemic in injecting and commercial sex networks. *Int'l J STD & AIDS* 18:486-492.
25 Stimson GV et al. (2010). *Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis*. London: International Harm Reduction Association.
26 Needle RH, Zhao L (2010). *HIV Prevention among Injection Drug Users: Closing the Coverage Gap, Expanding Access, and Scaling Up Core Interventions*. Washington D.C.: Center for Strategic and International Studies.
27 Mathers BM et al. (2010). HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet* 375:1014-1028.
28 National Emergency Response Council on HIV/AIDS (2010). *Monitoring the Declaration of Commitment on HIV and AIDS (UNGASS) – Swaziland Country Report*. Accessed on May 26, 2010 at http://data.unaids.org/pub/Report/2010/swaziland_2010_country_progress_report_en.pdf.
29 Human Rights Watch (2004). *Hated to Death: Homophobia, Violence and Jamaica's HIV/AIDS Epidemic*.
30 Baral S et al. (2009). HIV Prevalence, Risks for HIV Infection, and Human Rights among Men Who Have Sex with Men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE* 4(3):e4997.
31 Chakrapani V et al. (2008). *Sexual and Reproductive Health of Males-at-risk in India: Service Needs, Gaps, and Barriers*. New Delhi: International HIV/AIDS Alliance in India.
32 Human Rights Watch (2010). *"Skin on the Cable": The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia*.
33 Cardoso FH et al. (2009). The War on Drugs is a Failure. *Wall Street Journal*. February 23. Available at: http://online.wsj.com/article/SB123535114271444981.html. Accessed on May 20. 2010.
34 Kazatchkine M, Lange J (2006). Foreword. *Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice*. New York City: International Harm Reduction Development Program, Open Society Institute.
35 Murray LR et al. (2010). 'She's a professional like anyone else': social identity among Brazilian sex workers. *Culture, Health & Sexuality* 12:293-306.
36 Kerrigan D et al. (2008). Community development and HIV/STI related vulnerability among female sex workers in Rio de Janeiro. *Health Education Research* 23:337-345.
37 Rekart MI (2005). Sex-work harm reduction. *Lancet* 366:2123-2134.
38 Jana S et al. (2004). The Sonagachi Project: A Sustainable Community Intervention Program. *AIDS Education and Prevention* 16:405-414.
39 Beyrer C (2010). Global Prevention of HIV Infection for Neglected Populations: Men Who Have Sex with Men. *Clinical Infectious Diseases* 50:S108-S113.
40 Human Sciences Research Council et al. (2008). *The Johannesburg/eThekwini Men's Study (JEMS)*.
41 Ball AL (2007). Universal access to HIV/AIDS treatment for injecting drug users: Keeping the promise. *Int'l J Drug Policy* 18:241-245.
42 Wolfe D (2007). Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union. *Int'l J Drug Policy* 18:246-254.
43 Donoghue MC et al. (2007). Access to highly active antiretroviral therapy (HAART) for injecting drug users in the WHO European Region, 2002-2004. *Int'l J Drug Policy* 18:271-280.
44 Aceijas C et al. (2006). Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the 'Treating 3 Million by 2005. Making It Happen. The WHO Strategy' ('3 by 5'). *Addiction* 101:1246-1253.
45 De Joncheere K et al. (2009). *Evaluation of Access to HIV/AIDS Treatment and Care in Latvia*. World Health Organization and United Nations Office on Drugs and Crime.
46 WHO (2009). *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations*. Geneva.
47 Cohan E et al. (2006). Sex worker health: San Francisco style. *Sex Transm Infect* 82:418-422.
48 Ottosson D (2010). *State-Sponsored Homophobia*. Brussels: International Lesbian and Gay Association.
49 International Harm Reduction Development Program (2009). *The Effects of Drug User Registration Laws on People's Rights and Health: Key Findings from Russia, Georgia and Ukraine*. New York City: Open Society Institute.
50 Travel Resource Center (2010). Accessed on May 20, 2010 at http://www.indro-online.de/nia.htm.
51 International Planned Parenthood Federation et al. (2008). *Verdict on a Virus: Public Health, Human Rights, and Criminal Law*.
52 Jacobs A (2010). China Turns Drug Rehab Into a Punishing Ordeal. *New York Times*. January 7.
53 Maher L et al. (2007). Scaling up HIV treatment, care and support for injecting drug users in Vietnam. *Int'l J Drug Policy* 18:296-305.
54 Des Jarlais DC et al. (2007). Reducing HIV infection among new injecting drug users in the China-Vietnam Cross Border Project. *AIDS* 21(Supp. 8):S109-S114.
55 Brown H (2006). Russia's blossoming civil society holds the key to HIV. *Lancet* 368:437-440.
56 Anoma C. Telephone interview. April 12, 2010.
57 Kerrigan D et al. (2006). Environmental/structural interventions to reduce HIV/STI risk among female sex workers in the Dominican Republic. *Am J Pub Health* 96:120-125.
58 Lippman SA et al. (2010). Social-Environmental Factors and Protective Sexual Behavior Among Sex Wokers: The Encontros Intervention in Brazil. *Am J Pub Health* 100:S216-S223.
59 Shilts R (1987). *And the Band Played On*. New York: St. Martin's Press.
60 amfAR (2008). *The MSM Initiative*. Available at: http://www.amfar.org/uploadedFiles/Around_The_World/MSM/MSM%20initiative%20English.pdf.
61 International HIV/AIDS Alliance (2003). *Between Men: HIV/STI Prevention for Men Who Have Sex with Men*.
62 Lesotho National AIDS Commission (2010). *Status of the National Response to the 2001 Declaration of Commitment on HIV and AIDS*. Available at: http://data.unaids.org/pub/Report/2010/lesotho_2010_country_progress_report_en.pdf. Accessed on May 30, 2010.
63 Office of Global AIDS Coordinator (2009). *The U.S. President's Emergency Plan for AIDS Relief: Five-Year Strategy*. Available at: http://www.pepfar.gov/strategy/document/133244.htm. Accessed on May 21, 2010.
64 International HIV/AIDS Alliance (2009). *Responding to the HIV-related needs of MSM in Africa*.
65 Pan American Health Organization, (2010). *Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men Who Have Sex with Men in Latin America and the Caribbean*. Available at: http://new.paho.org/hq/index.php?option=com_content&task=view&id=2449&Itemid=1993. Accessed on May 30, 2010.
66 PCB NGO Delegation to the UNAIDS Board (2010). Stigma and Discrimination: Hindering Effective HIV Responses. Available at: http://unaidspcbngo.org/wp-content/uploads/2010/05/2010_NGO_Report_Final_website.pdf. Accessed June 30, 2010.

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