REVIEW ARTICLE

Money, Power and HIV: Economic Influences and HIV Among Men who have Sex with Men in Sub-Saharan Africa

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Abstract

Despite consistent evidence, effective interventions and political declarations to reduce HIV infections among men who have sex with men (MSM), coverage of MSM programmes in sub-Saharan Africa (SSA) remains low. Punitive legal frameworks and hostile social circumstances and inadequate health systems further contribute to the high HIV burden among MSM in SSA. The authors use the Modified Social Ecological Model to discuss economic influences in relation to HIV and MSM in SSA. Nigerian, South African and Ugandan case studies are used to highlight economic factors and considerations related to HIV among MSM. The authors argue that criminalisation of consensual sexual practices among adults increases the frequency of human rights violations contributing to the incidence of HIV infections. Furthermore, marginalisation and disempowerment of MSM limits their livelihood opportunities, increases the prevalence of sex work and drug use and limits financial access to HIV services. Sexual and social networks are complex and ignoring the needs of MSM results in increased risks for HIV acquisition and transmission to all sexual partners with cumulative economic and health implications. The authors recommend a public health and human rights approach that employs effective interventions at multiple levels to reduce the HIV burden among MSM and the general population in SSA. *(Afr J Reprod Health 2014; 18[3]: 84-92)*

Keywords: HIV, men who have sex with men, Africa, key populations, social economic risk factors

Résumé

Malgré les preuves cohérentes, les interventions efficaces et les déclarations politiques visant à réduire les infections par le VIH chez les hommes qui ont des rapports sexuels avec des hommes (HSH), la couverture des programmes des HSH en Afrique subsaharienne (ASS) reste faible. Les cadres juridiques punitifs et les circonstances sociales hostiles et les systèmes de santé inadéquats contribuent également à la charge élevée du VIH parmi les HSH en Afrique subsaharienne. Les auteurs utilisent le modèle socio-écologique de modification pour discuter les influences économiques en rapport avec le VIH et les HSH en Afrique subsaharienne. Les études des cas venant du Nigeria, de l'Afrique du Sud et de l'Ouganda sont utilisées pour mettre en évidence les facteurs économiques et les considérations liées au VIH parmi les HSH. Les auteurs soutiennent que la criminalisation des pratiques sexuelles consenties entre adultes augmente la fréquence des violations des droits de l'homme qui contribuent à l'incidence des infections du VIH. En outre, la marginalisation et de l'impuissance de HSH limite leurs moyens de subsistance, augmente la prévalence de la prostitution et la consommation de drogues et limite l'accès financier aux services liés au VIH. Les réseaux sexuels et sociaux sont complexes et en ignorant les besoins des HSH dans les résultats des risques accrus de contracter le VIH et la transmission de tous les partenaires sexuels ayant des implications économiques et cumulatifs sur la santé. Les auteurs recommandent une approche de la santé publique et les droits de l'homme qui emploie des interventions efficaces à plusieurs niveaux afin de réduire le fardeau du VIH parmi les HSH et la population entière en Afrique subsaharienne. *(Afr J Reprod Health 2014; 18[3]: 84-92)*

Mots-clés: VIH, les hommes qui ont des rapports sexuels avec des hommes, Afrique, populations clés, facteurs de risque socio-économiques

Introduction

In 2013, approximately 35 million people were living with HIV and during that year about 2.3 million people became infected with HIV across the world[1]. Despite increased access to HIV counselling and testing (HCT), linkage to care and antiretroviral therapy (ART), HIV continues to be a major contributor to the global burden of disease[2]. However, in many contexts the burden

of disease is disproportionately higher among certain key populations. These key populations include people with higher risk for the acquisition and transmission of HIV than other adults of reproductive age, and includes men who have sex with men (MSM), sex workers, people who inject drugs and transgender people[3]. This paper aims to highlight the pathways along which social, economic and behavioural factors influence the risk for HIV infection and its consequences among MSM in sub-Saharan Africa (SSA) from an economic perspective. Specifically, this paper outlines how policies, laws, community attitudes, health system access, sexual networks and behaviours are influenced by economic factors, which modify HIV risk among MSM in SSA.

Methods

The authors reviewed the literature from social science and public health disciplines and policy documents around economic considerations and influences affecting the HIV epidemic among MSM in SSA. The findings were analysed using a Modified Social Ecological (MSE) model focusing on MSM and HIV in SSA, from an economic perspective. This model is composed of five levels (See Figure 1).

The first level, HIV Epidemic Stage, reviews the HIV epidemic and transmission dynamics within the target population. Analysis at the Public Policy Level is focused on policies that may reduce or enhance HIV risk. Analysis at the Community Level reviews access to prevention, treatment, care and support services and how these components influence health. At the Social and Sexual Network Level, the model is used to analyse the influence social factors have on HIV risk. Finally, biological and behavioural factors that influence risk are analysed at the Individual Level[4]. The authors then applied the MSE model to MSM in differing legislative environments as part of country-specific case studies.

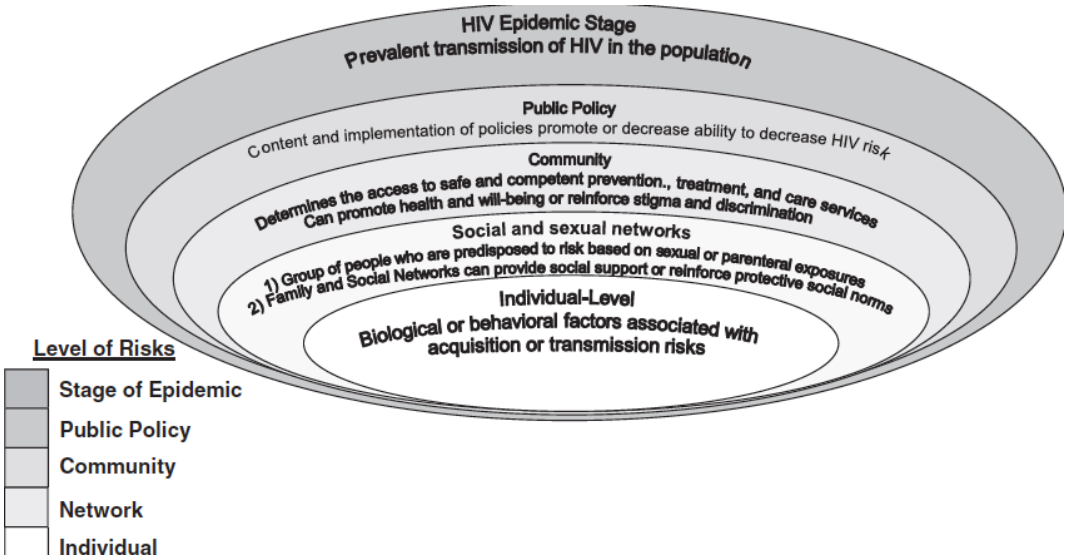

Figure 1: The modified social ecological model[4]

Findings

An overview of the HIV epidemic among MSM in sub-Saharan Africa is provided. Thereafter, the levels of the MSE model are discussed in relation to key economic factors and consequences related to HIV among MSM in SSA. Case studies from Nigeria, South Africa and Uganda are presented. The authors describe pathways linking the health and rights of MSM in SSA to economic

considerations. The authors finally provide suggestions to address factors that could mitigate HIV risk and the HIV burden among MSM, and the broader population, in SSA.

The HIV Epidemic Among MSM in sub-Saharan Africa

Data on the burden of HIV, including incidence and prevalence data, among MSM across the sub-Saharan region remains relatively limited. Where studies have been done, HIV prevalence among MSM is over three times higher than among other men of reproductive age[5]. Moreover, these comparisons have been conservative given that most samples of MSM have included mostly young men who have a higher HIV incidence and lower background HIV prevalence compared to older MSM[6]. Despite limitations of data availability and external validity, the emerging picture suggests that gains made in reducing HIV infections and the associated burden among the general population in SSA has generally not extended to benefit MSM and their sexual partners[7].

Public Policy

From a public health and human rights point of view, all people have the right to health[8]. Legislation that criminalises same sex practices contributes to the political and social marginalisation of individuals that may engage in those practices. As such, many behaviours continue, but occur occultly to minimise the risk of bribery, extortion, blackmail, violence, arrest and imprisonment[9]. Occult sexual behaviours may prevent discussions around HIV status and safer sex, including risks around unprotected anal sex, and can render access to lubricant challenging[8]. In contexts where laws prevent the provision of health services to MSM, health care workers are unable to provide such services[10]. Since the passing of more punitive laws towards same sex practices in Nigeria and Uganda in 2014, human rights abuses affecting MSM have already been reported, including the arrest and detainment of 54 MSM and murder of at least one MSM in these countries[11–13]. The number of MSM that have been blackmailed or harassed remains unknown, but this number is likely to increase and contribute to on-going efforts to conceal same sex practices by MSM in these countries, increasing the likelihood of occult sexual practices and the risks associated with them.

MSM who work in contexts where their rights are protected are able to take action when they are discriminated against. For example, MSM in South Africa may report discrimination on the basis of their sexuality to the Commission for Conciliation, Mediation and Arbitration or to their union representative[14]. In contrast, MSM within hostile legislative frameworks are vulnerable to discrimination, harassment, bribery and extortion in their places of work – without access to legal recourse.

Public health policy that does not highlight the need for MSM-focused interventions prevents appropriate budgeting. Between 2007 and 2012, less than US$ 2 million was spent on MSM programming in sub-Saharan Africa. In comparison, about US$ 9.9 billion was available for HIV treatment and care in low- and middle-income countries in 2012[1]. The mismatch between relative HIV burden and investments in HIV prevention, treatment and care for MSM and the broader population needs to be addressed if the Joint United Nations Programme on HIV and AIDS (UNAIDS) mission of zero new infections is to be reached[15].

However, HIV policies that support MSM-focused service provision will be in conflict with laws that criminalise same-sex practices. In Nigeria and Uganda, laws that criminalise same sex practices have negatively affected MSM-focused services provision and donor support in these countries[10]. However, removal of financial support may not be the most effective method to address this issue – as many HIV-related services are made accessible to MSM through donor funding. The Nigerian and Ugandan case studies highlight consequences of current unsupportive legislation on MSM, from an economic perspective.

Case Study: Economic Dimensions of the Anti-Homosexuality Act (AHA) in Uganda

In October 2009, a member of the parliament of the Republic of Uganda introduced a private

member's bill to make 'completely illegal' all acts of homosexuality. The bill was wide ranging, increasing criminalisation of homosexuality, including 'homosexual touch', mandating death for some acts including for 'repeat offenders' and 'homosexual sex when HIV positive' and criminalising 'promotion of homosexuality'. In December 2013, the Ugandan Parliament passed the law and the President signed it into law in February 2014[16].

The personal costs of the new law are considerable. Research done before enactment showed high levels of stigmatisation of MSM in Uganda. HIV prevalence among MSM in Kampala is three times higher than that of other men, and the odds of being HIV infected is significantly higher among MSM who have experienced homophobic abuse compared to those that have not[17]*. Many MSM in Uganda take considerable steps to prevent being exposed as being MSM, including frequently changing their place of residence and holding expensive wedding ceremonies with a female partner to publicly display normative heterosexual behaviour*[18]*. Despite these efforts, many MSM experience blackmail and police harassment*[18].

Some MSM in Uganda have been asked by landlords and local community leaders to leave their place of residence due to a clause in the recently enacted law that criminalises renting premises to gay Ugandans[19]*. Other MSM have left the country, some temporarily to Kenya and others to Rwanda. However, MSM who move to neighbouring countries are likely to experience high levels of stigmatisation there too. Furthermore, MSM who are exiled are at risk of further economic marginalisation and face additional barriers to accessing health services*[20]*. The publication of the names of 200 homosexuals in Uganda by a local newspaper in February 2014 contributed to this exodus*[21]*. Some MSM are opting for asylum, which entails dislocation and indefinite periods waiting in limbo. MSM opting for asylum will incur costs to obtain visas and travel to enter a country that is supportive of the rights of MSM. MSM who remain in Uganda are likely to continue their efforts to keep their sexuality private. Some of the MSM exposed in the newspaper article lost their jobs and livelihoods*[18].

The effects of the new law on the MSM community are considerable. Stigma towards MSM accessing health service in Uganda were barriers to health services before the AHA was signed into law[18]*. MSM are now more likely to prevent exposing their sexual practices to health providers as they may experience severe consequences if this is revealed, especially with the attack on the Walter Reed HIV research site and arrest of staff conducting an acute HIV infection study among key populations in Kampala. This may mean late diagnosis, complications of infections and increased likelihood of onward transmission of sexually transmitted infections among MSM and their sexual partners. Before the law was enacted, the first lesbian gay bisexual transgender intersex (LGBTI) clinic faced considerable official opposition*[22]*. The new law has forced this organisation to provide services 'underground'. MSM are likely to fear more exposure by going to a place that is known to be MSM friendly. Access to government clinics may be out of the question because of stigmatisation or open hostility by government agencies towards MSM*[23,24]*. The United States Government has opted to review HIV-related funding to Uganda, and a study planned to address gaps in strategic information among MSM has been suspended because of current anti-gay sentiments*[25]*. On the positive side, community organisations that support the MSM community may be able to access more funding, but these programs will remain illegal and underground.*

The AHA gained international outrage and caused the withdrawal of considerable aid support to the Ugandan government [26–29]*. This will have direct effects on the country's economy, with loss of jobs, livelihoods and lives.*

Case Study: Nigeria

Same sex behaviour and conduct has been criminalised in Nigeria under Chapter 21,

sections 214, 217 and 229 of the Nigerian "Criminal Code Act" and sections 130, 131 and 314 of Sharia penal code applicable in 12 northern states of Nigeria[30]*. However, mounting epidemiologic evidence in the last seven years has demonstrated increasing prevalence of HIV among MSM in Nigeria*[31–34]*. However, the MSM population size in Nigeria is unknown.*

The government of Nigeria developed the National HIV and AIDS Prevention Plan (NPP) in response to the critical need to address the HIV-related needs of all people, especially those at the highest risk[35]*. The NPP provides a strong and comprehensive framework for prevention efforts for all target groups including MSM in line with the National HIV and AIDS Strategic Plan*[36].

Over the last seven years (2006-2013), funding for HIV prevention, treatment, care and support services for MSM in Nigeria has increased. The majority of MSM-focused funding has come through the United States President's Emergency Fund for AIDS Relief (PEPFAR); the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank.

The signing of the same-sex marriage law on the 7th of January 2014 by the President of Nigeria has far reaching public health, human rights and economic implications. Because the law carries 14 years imprisonment, there have been reported cases of MSM community members leaving their place of residence for fear of being exposed. Attendance at clinics providing prevention, treatment, care and support services for MSM has also been lower than expected. The new law has also contributed to the withdrawal of MSM-focused services by several organisations. In effect, the law has contributed to increased criminalisation of MSM, which has in turn increased the incidence of violence, stigma, discrimination, homophobia, extortion, and arrests of MSM in Nigeria. Furthermore, because Section IV of the law carries up to 10 years' imprisonment for any person who supports the registration of gay organisations, meetings or provides services for MSM the provision and access to essential HIV services is threatened. This undermines the Presidential Comprehensive Response Plan on HIV targeting Key Populations including MSM in Nigeria. The law further threatens the limited funding for MSM thereby reversing the gains of previous and current efforts to address the needs of MSM in Nigeria.

To sustain continued provision of tailored comprehensive combination prevention interventions to meet the needs of MSM in a homonegative environment, there is a need to modify intervention strategies from peer group focused approaches to more resource demanding individualized approaches. This will have far-reaching economic implications in the short term and threaten the impact and sustainability of programmes in the long term.

In South Africa, funding for MSM-focused programming over the last few years has increased in line with supportive public policy. The health outcomes of MSM, their sexual partners and broader society has increased as a result of increased support and funding for MSM programmes[37].

Case study: The South African Perspective

The South African Constitution outlines freedom from discrimination on any basis, including sexual orientation[38]*. The protection of rights to freedom from discrimination based on sexual orientation has enabled legal recourse in instances of discrimination towards specific groups of people, including MSM*[39].

The social capital of MSM has increased due to supportive policy and active civil society mobilisation[40]*. Such social support and inclusion has increased resilience against many social factors that contribute to HIV risk among MSM*[8].

The South African National Strategic Plan on HIV, STIs and TB (2012 – 2016) defines MSM as a population in need of HIV prevention services. The plan also highlights the negative

effects that stigma and discrimination have on the HIV response[41]*. Recently, the National Department of Health, the South African National AIDS Council and partners initiated a pilot intervention to address discrimination by health workers towards MSM who access health facilities. SANAC, GFATM, PEPFAR and MSM civil society organisations have also been influential in increasing funding for MSM-focused services in South Africa. As a result the numbers of MSM accessing HIV services is increasing*[37]*. However, even in South Africa, the negative effects of discrimination towards MSM are evident – with several MSM having been murdered and attacked in the last year*[42]*. Further change is needed for MSM in South Africa to realise their full potential.*

Community Level Factors

The exclusion of MSM from society contributes to their vulnerability to HIV infection and its consequences[43]. Exclusion by community members has social as well as economic dimensions, which are linked to HIV risk. Increased HIV burden has an economic impact on the individual, their household and the health system[15].

Moral judgment, criminalization, stigma and discrimination are important factors that lead to marginalization, exclusion and disempowerment of MSM in SSA[40]. Disempowerment contributes to increased vulnerability to HIV, increased risk of negative consequences of infection and a higher probability of singular HIV transmission[8].

Social and economic exclusion of MSM limits their socio-economic options[44]. As such, many MSM may use sex work as a livelihood option[45]. The lack of condom compatible lubricant increases the likelihood of unprotected sex or the use of non-condom compatible lubricant[46]. Several of these examples are influenced by policy and community level factors, but translate to practices associated with increased risk for HIV infection and transmission at the individual level.

Social and Sexual Networks

Human rights violations are symptoms of stigma and can obliterate social capital among MSM, as was observed with the recent violence affecting MSM in Uganda and Nigeria. The lack of available economic opportunities available for MSM has resulted in higher rates of commercial sex among MSM in SSA. Furthermore, higher rates of unprotected anal intercourse have been found among MSM who engage in compensated sex compared with uncompensated sex[47–50].

Individual Level Factors

Individual risks for MSM have been defined primarily through research in high-income countries, but remain pertinent in defining MSM risks across SSA[5,51]. Risks for MSM, such as unprotected receptive anal intercourse, high frequency of male partners, and a high number of lifetime male partners are influenced by economic factors[52]. For example, the cost of purchasing condoms and condom-compatible lubricant decreases the likelihood of their use. Partner frequency may also be influenced by use of sex in exchange for goods, services and money. The cost of private, confidential health services may act as an additional barrier to MSM accessing prevention, treatment and care services.

Concurrently, MSM who use drugs may also be at increased risk for HIV transmission. Furthermore, economic hardships may contribute to substance use as a coping mechanism to manage the effects of stigma and discrimination[5,53–55]. Suppression of HIV through ART can effectively prevent HIV infection[56]. Financial accessibility of ART for MSM is therefore key to preventing onwards transmission of HIV.

Conclusion and the Way Forward

MSM in SSA are living in a challenging time as punitive legislation and the expression thereof is increasing. As a result, new HIV infections among MSM and their sexual partners and broader society (and the associated morbidity, mortality and economic cost there of) are inevitable without resolute action to address multiple factors at several levels that increase HIV risk among MSM in SSA.

On a macro level, policy should be informed by evidence and should be rights-affirming. Significant increases in the financing of MSM-

focused interventions in SSA is needed to reduce the sexual transmission of HIV by 2015[57]. On a community level, social acceptance of MSM and increased awareness of the negative consequences of discrimination needs to be fostered. Research documenting the experiences and risk of MSM across SSA under legal frameworks could inform future responses. Health worker capacity building that enables the provision of non-discriminatory, competent services to MSM is needed. On the social and sexual network level, MSM participation in policy and programme development and implementation is essential. Networks that build social capital and resilience need to be established and strengthened to nurture MSM-led responses to HIV. On an individual level, MSM require access to a package of essential HIV-related services as well as harm reduction and psychological services to prevent and mitigate the effects of HIV infection and the consequences of unsupportive social and structural influences.

It is essential to note that health is a human right. As such, HIV responses that take economic, health and human rights considerations into account are more likely to result in the end of AIDS than responses that do not[15].

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