Parallel Review on Innovative Key Populations models for programming

Introduction

The United Nations General Assembly has committed to ending the AIDS by 2030. Intermediate goals include reducing new HIV infections by 75% and reducing AIDS-related deaths to fewer than 500,000 globally (PAHO, 2019). Criminalisation, poverty, institutional inequality, harmful cultural practices, infringement on bodily autonomy and a lack of representation are aggravating factors to key populations, women and youth being left behind in state health responses. More importantly, these groups are unique in circumstances and intersecting in struggles. There are youth who identify as MSM and engage in sex work. Similarly, there are transgender individuals living with HIV. The need for broadening or allowing for intersecting identities and struggles is key to curbing new HIV and STI incidents. Key to this, is the inclusion of civil society within health systems at design, resourcing, implementation, monitoring and reporting stages.

Engagement and Evidence

Identifying the most marginalised and vulnerable is key to achieving equitable health outcomes. This requires identifying and acknowledging those most far left behind in the HIV response and understanding any underlying issues that intersect and aggravate vulnerabilities. This means linking operational, qualitative, and quantitative data in a manner that can bridge the gap between the most at risk or key populations with the general public. This is a founding principle for better integrated services and enabling universality in health services and care. This will incorporate social determinants, legal barriers and contextualise the response (WHO, 2016). Success Capital further argues decolonising the HIV response in language, flexibility in resourcing and incorporating traditional means of demand creation and stimulating health seeking behaviour. This requires Botho, respect, infrastructural investments in communities and continuous engagement for improvement.

Data on size estimates, treatment cascades and surveillance are important – however, they will not be as impactful given the high levels of domestic mobility among key populations. Where relationships, sex partners and securing employment can be based in different locations or health facility service points/regions. This means strengthening the quality and monitoring aspects of programming in real time (Wolf, et al., 2018). It further requires of building and maintaining rapport, relations and trust with community members. These are variant in experiences as credibility, mental safety, self-stigma, full disclosure when seeking help, and demand for health commodities are all deeply subjective, personal and can be politicised at a community level. This further expands to understanding the outcomes of health interventions, policy and partners.

Outcomes

Understanding and defining what is of value to key stakeholders is essential in conducting evaluations (Oosterhoff & Kort, 2014). There can be misalignment between state driven outcomes and community aspirations. For example, ‘capacity building’ as it is framed assumes that community members have no capacity or understanding as a basis to health seeking behaviour or safe sex. Although there are variants and different influences on this, it voids of at risk or affected person’s existing efficacy, cognitive ability, and knowledge. On the other end, community members have been sensitised, informed, and targeted in different campaigns and even community led programming – yet still contract STIs and have risky sex. ‘Capacity strengthening’ could bridge these two

perspectives, framing the possibility of knowledge whilst acknowledging that it is not always applied. This can always be determined as a result of substance use, no consent, intimate partner violence, limited negotiation power for safe sex or simply perceptions of better pleasure in unsafe sex. Just as artificial intelligence serves as a continuous learning and improvement mechanism for the advancement of technology and consumption – so should feedback and improvement systems be implemented throughout the referral health system.

Increased Investments

Investment in key populations is cost-effective as they are central to the HIV response. There can be a multiplier effect (NASCOP, 2014) considering some would have clients, partners who use substances or be in non-monogamous relationships. Understanding the underlying influences of sexual practices, social engagement and pleasure is critical to scaling and adapting programming. This would mean increased investments in community led and driven research, operational research systems and feedback loops for tailoring programming. Increasing the understanding of integrated services is critical for accommodating key populations in broader health outcomes (UNAIDS, 2016). This would result in a more holistic approach to prevention at individual, community, and population levels (USAID, 2019). It encompasses broader structural investments in countering harmful gender norms, removing colonial era laws and approaches to knowledge production, scaling mental health infrastructure and strengthening efficacy through social determinants of eliminating poverty, securing livelihood, escaping violence through community specific shelters and safeguarding institutional representation beyond advisory roles.

Towards better integration and sustainability

Strengthening governance and accountability by including communities can increase the quality of health services (WHO 2015). They are central to monitoring and improving integrated service provision (CeSHHAR, 2017). This would help accelerate broader universal health service and care in the public health system – eliminating systemic inequity in access, uptake, and adherence of key populations. Alternatively, community led civil society can be resourced and strengthened as an extension of the public health system – not only complimenting as some do now but scaling to broaden health responses to key populations. This would ensure that overall health outcomes, inclusive of non-communicable diseases can be integrated across the country's health systems to include key populations. Either of the approaches would ensure the country meets its commitments, stimulates collaboration, and safeguards domestic resources in spending and skills towards a more equitable value chain for universal health coverage.

Integrating sexual and reproductive health and rights within the HIV response would be a strategic enabler for better health outcomes. Given the unique needs, circumstances, health seeking behaviour and implications of key populations' environments (Knowledgesuccess, 2013); family planning would be well placed within community led organisations. It would allow for better uptake and value for client needs whilst eliminating social determinants that negatively impact both HIV and STI outcomes. It would align with international and domestic commitments in safeguarding health (SADC, 2018). Seeking assistance from one facility is far better, more convenient, evidence-driven, and practical than having to access different facilities for different needs. Inclusion in National HIV strategies, removing discriminatory laws is key (McCartney, 2014) but

not enough. Quality of health commodities and services for key populations is critical but remains an area of growth (Burrows, et al., 2019). This should reflect in the form of client satisfaction, availability of options and return visits to the same facility. These kinds of indicators should be validated at a community level to ensure alignment of outcomes and meaningful impact.

Sub-population specific considerations

There is a strong need to overcome barriers to effective HIV responses for key populations (Nyato, et al., 2018). This should incorporate mental health, changes in how one identifies and intersecting vulnerabilities such as poverty, homelessness, surviving abuse, multidimensional sub-population affiliation and navigating phobias in daily experiences. More community specific insights are detailed below:

Men who have sex with men (MSM)

Men, particularly those between 25-34 years, access HIV testing and treatment at low rates (PEPFAR, 2020). In Botswana's context, these fall under the youth bracket. Traditional approaches such as the static Modes of Transmission (MOT) model for estimating new HIV infections on MSM are not enough, as secondary indirect transmissions are possibilities (Amrita Rao, et al., 2018) noting MSM and the wider LGBTIQ+ community's social and sexual links within and outside the community. Removing national identity detail registers in initial screening could be a approach for securing MSM as return clients. Particularly those who are mobile in residence, work and through relationships. Eliminating barriers of specific criteria to extend services, such as citizenship, disclosing sexual orientation or others would increase comfort levels for MSM. Furthermore, given the relatively small population numbers and possibility of high familiarity; MSM would not want to be assisted by people they might be in similar social and relationship circles with or that they would encounter in public spaces. Those uncomfortable with their sexuality or same-sex partner relations would not want any links or familiarity when seeking health services.

Female and male sex workers

Population-based data on sex workers is difficult to obtain given criminalisation and and difficulty in self-determination and consensus on sex work in daily experiences. Although there is high prevalence and documented work on female sex workers, there are gaps in sourcing the same for male sex workers in Botswana. This does not mean they do not exist. Success Capital's work has broadened to include male SW given the high prevalence during the COVID-19 crisis. HIV prevalence rates among for sex workers have been limited and are focused on street and brothel female workers (PAHO, 2011). Significant work is needed to incorporate and understand social determinants and influences in sex activity of both sex workers and their clients. Male sex workers have varied confidence or denial levels in respect of transactional sex and relationships. Some engaging with women and others with men and other segments of the LGBTIQ+ in variants. This fluidity is partly attributed to male privilege, that allows to navigate different key populations and the general public without fear of consequence. Those who are more effeminate identify as gay and have aggravated vulnerabilities of violence and discrimination. Female SW are further vulnerable because of nuances of negotiating power for safe sex, navigating abusive working conditions and risking encounters with law enforcement. There are varying influences impacting sex activity between citizen and foreign national SW. These are critical to understanding for tailoring services and strengthening the HIV response.

Adolescent girls and young women (AGYW)

Adolescents continue to be a concern for HIV, with increases in HIV related rates (Bekker, et al., 2015). Some conflating experiences in sex work and LGBTIQ+ community affiliation makes it difficult to better understand underlying determinants of sex activity. Early unintended pregnancies, consent and harmful cultural norms have impacted how effective HIV interventions have been for AGYW. Intersectionality is key in comprehensive HIV prevention and treatment packages, with a priority to weave SRHR to prevent new HIV incidents. Innovative approaches to AGYW who are part of key populations should not be limited to linear interventions. Structural impediments such as family economic disposition, peer pressure, psychosocial influences on early sex introduction and intergenerational nuances in cultural norms need to be addressed. Investments should not isolate learning to sexual intercourse; but should strengthen efficacy, challenge toxic masculinity, and stimulate avenues for citizen reporting on social determinants impacting HIV and other STIs.

Other groups

Transgender men, transgender women, lesbians, gender non-conforming, people living with disabilities, including those with underlying mental health conditions and intersex individuals should be considered. This requires a comprehensive understanding of intersecting vulnerabilities that compound susceptibility to contracting HIV or other STIs. The inclusion of these other groups largely relies on framing and social determinants of becoming and belonging. Integrating their unique needs does not take resources away from key population responses. It does, however, allow for fluidity and accommodating key populations in transition, those on hormonal therapy and those who are inclined to avoid services as they might go against their identity and/or expression. Strengthening civil society to adequately meet and align HIV programming with their scientific and social needs would ensure that no one is left behind in the HIV response.

Select Observations

Pre-exposure prophylaxis (PrEP) is a key HIV prevention tool that has had success in PEPFAR funded programmes. Although many service delivery points have strengthened infrastructure and referral services; uptake and adherence in Botswana has not been as successful. Demand creation and underlying social determinants need to be better understood and articulated. This would align well with further investments in research systems that allow for more impactful programming. Multi-stakeholder collaborative efforts are needed (Djomand, et al., 2018); this should expand beyond existing health referral relationships and technical working groups. Education, SRHR, Business and other sectors would be enabling and complimentary in not only fulfilling HIV outcomes but building partnerships for long term resource diversification and strengthening youth engagement at community, district, and country levels.

Qualitative findings suggest that interventions are more impactful when they are judged as appropriate and acceptable by the target population; delivered by people with relevant personal experience and addressing broader social and cultural influences through partnership with and education of community leaders (Ensor, et al., 2019). This aptly covers the purpose of Success Capital's mandate and further affirms the saying 'nothing for us without us'. Scaling programming and strategic advocacy would support eliminating structural barriers to HIV prevention and treatment for key populations. This would not only de-politicise and un-sexualise key populations and HIV, but it would normalise conversations around sex,

health seeking behaviour and strengthen social behavioural change.

Emerging challenges of personal development in teenage years and early adulthood need to be mitigated. The complex physical, psychological, emotional, and social changes that occur in adolescence have immediate and long-term implications for individuals. Compounded by surviving abuse, phobias, poverty and homelessness: many young key populations seek psychosocial and structural support. LGBTIQ+ shelters are critical for belonging and becoming. Particularly for youth that are denied family acceptance and dwelling, escaping abusive relationships they depended on or ended up out of school and ineligible for state social protection. An LGBTIQ+ youth shelter provides some infrastructure for more dignified means to building autonomy and efficacy. This improves one's chances of HIV prevention or treatment uptake and adherence. More importantly, a shelter can provide support for mental health disorders that might emerge with coming of age, accepting one's identity or even receiving gender affirmative healthcare (Delany-Moretlwe, et al., 2015). Eliminating new HIV incidents should not solely depend on conventional HIV programming, but holistic, enabling and strengthening services and care at individual and community levels. This extends health provision to dignified wellbeing.

LGBTIQ+ shelters further limit community challenges of keeping appointments and referrals from multiple facilities (Department of Health and Human Services, 2013). It would also allow for early detection, treatment enrolment and ease of treatment refills (Ibiloye, et al., 2018). This would be one way to pilot the feasibility of comprehensive health services from one service point. Allowing for building evidence and exploring different ways towards universal health coverage as it is a challenge throughout Southern Africa (FHI360, 2017). Community roadshows that include documentary screenings and dialogues would further eliminate qualitative structural barriers. Visual, audio and in person engagements would allow for indigenous, exploratory, and collective community consensus on eliminating harm against key populations. This would further strengthen education drives and demand creation for HIV prevention. It replicates the customary court system that is anchored on community dialogue and Botho.

Lessons from other epidemics

Ebola highlights an increase in treatment centers, rapid recruitment and training of teams and civil society engagement as key actions of success (Institut Pasteur, 2016). TB taught not to send people living with HIV to TB hospitals, essentially sending immunocompromised people to facilities with weak infection control and multiple active cases of TB (Kankadze, 2018). This strengthens arguments for key population or unique vulnerability centers of excellence. Where primary care could be universal across all health facilities, with specialist support centers for LGBTIQ+ and/or SW respectively. Whilst several months of COVID-19 precautions have occurred, a lot is yet to be understood. Civil society has played a role in communications and working around precautions to meet HIV programming demands. However, significant gaps remain in uncertainty, resourcing, and collaborative efforts for integrating and aligning to a different operating landscape. The economic, social, and normative impact of lockdown, state of emergency, physical distancing has only illuminated why these are critical factors to consider in a health response. Further work is in progress to better understand and align variant lessons learned from COVID-19 to build a comprehensive package that is tailored to differentiated and unique needs of key populations in Botswana.

Conclusion

HIV prevention remains a key determinant of the HIV response and outcomes at all levels of governance. Many civil society organisations align to funding parameters, and thus need concerted effort and advocacy to shape increased investments that allow for tailor-made, comprehensive and responsive needs of communities they serve. Comprehensive condom distribution, PrEP, SRHR, advocacy against structural barriers, integrating innovative tools for indigenous knowledge and strengthening efficacy are key determinants for successful HIV and broader health outcomes that impact key populations. Data collection is critical for enabling innovation and future-fit service provision and care (WHO, 2018). Key to this is strengthening civil society in scope and partnerships (Gatimu, et al., 2019). This will allow for working beyond normative programming in areas where government and bilateral partners might not be able to take risk or be agile to do so. Further research and interventions that consider prisoners being included as key populations and building LGBTIQ+ shelters would be key to accelerating progress. Notably, as per Dr Stefan Baral states: 'All countries need to work with key populations, because they represent cost-effective opportunities for prevention; their contributions to the epidemic are much higher relative to their overall population size' (SOAR, 2019).

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