Key Populations, Key Solutions


Men who have sex with men
Sex workers
Injecting drug users
Prisoners
Migrant populations
Transgender people

October 2011
Key Populations, Key Responses

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October 2011

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III. Methodology

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List of Acronyms and Abbreviations

ART Antiretroviral Therapy
CDC Centre for Disease Control
BCC Behaviour Change Communication
DTHF Desmond Tutu HIV Foundation
HCT HIV Counselling and Testing
IDU Injecting Drug User
IEC Information, Education and Communication
iPrEX Pre-exposure Prophylaxis Trial among Men Who Have Sex with Men (MSM)
IOM International Organization for Migration
LGBTI Lesbian Gay Bisexual Transgender and Intersex
MDG Millennium Development Goals
MSM Men Who Have Sex with Men
NGO Non-governmental Organisation
NSE Needle Syringe Exchange
NSP National Strategic Plan
OGAC Office of the U.S. Global AIDS Coordinator
OST Opioid Substitution Therapy
PAP smear Papanicolaou Test
PEP Post-exposure Prophylaxis
PEPFAR President’s Emergency Plan for AIDS Relief
PrEP Pre-exposure Prophylaxis
SADC Southern African Development Community
SANAC South African National AIDS Council
SANCA South African National Council on Alcoholism
SASWA South African Sex Workers Alliance
STI Sexually Transmitted Infection
SW Sex Worker
SWEAT Sex Worker Education and Advocacy Taskforce
SWOC Strengths Weaknesses Opportunities Challenges
TB Tuberculosis
URAI Unprotected Receptive Anal Intercourse
UN United Nations
UNDP United Nations Development Programme
UNFPA United Nations Population Fund
UNGASS United Nations General Assembly Special Session
UNHCR United Nations High Commissioner for Refugees
UNODC United Nations Office on Drugs and Crime
VCT Voluntary Testing and Counselling
WHO World Health Organization
**Glossary**

**IDU**
Injecting drug user. Drugs may be injected through subcutaneous, intramuscular and intravenous routes.

**MSM**
MSM is an abbreviation used for ‘men who have sex with men’ or ‘males who have sex with males’. The term ‘men who have sex with men’ describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men. However, abbreviations should be avoided whenever possible. Writing out the term is preferred.

**PEP**
Post-exposure prophylaxis (PEP) refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection. The latter is sometimes referred to as N-PEP.

**PrEP**
Pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure or possible exposure to HIV. PrEP strategies under evaluation increasingly involve the addition of a post-exposure dosage.

**Reassignment surgery**
Sex reassignment surgery (also known as gender reassignment surgery, genital reconstruction surgery, sex affirmation surgery, sex realignment surgery or sex-change operation) is a term for the surgical procedures by which a person’s physical appearance and function of their existing sexual characteristics are altered to resemble that of the other sex. It is part of a treatment for gender identity disorder/gender dysphoria in transsexual and transgender people. It may also be performed on intersex people, often in infancy and without their consent.

**SADC**
The Southern African Development Community (SADC) is an inter-governmental organisation headquartered in Gaborone, Botswana. Its goal is to further socio-economic cooperation and integration as well as political and security cooperation among 15 southern African states. It complements the role of the African Union.

**Sex work**
Pertains to sex between consenting adults over the age of 18, either regularly or occasionally, formally or informally, for cash, kind or services, where the person selling sex may or may not self-identify as selling sexual services.

**Sex worker**
The term ‘sex worker’ is intended to be non judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally.

**STI**
Sexually transmitted infection. Infection transmitted and acquired through sexual contact.

**Transgender**
A transgender person has a gender identity that is different from his or her sex at birth. Transgender people may be male to female or female to male. Transgender persons may also prefer not to conform to any gender binary and to instead use gender neutral references.
Executive Summary

Key Populations and HIV

A comprehensive contextual understanding of the HIV epidemic is required in order for effective HIV interventions to be developed and implemented. The South African HIV epidemic is diverse and within the generalised epidemic there are several concentrated epidemics, which play an important role in the spread of the epidemic and its effective control. The exclusion of groups who are at increased vulnerability to HIV, the acquisition of HIV and the impacts of HIV, or who are on the margins of society, undermines the ability of any response to be effective, while contravening human rights and public health principles of freedom from discrimination and access to health services. Individuals and populations can only reach their maximum potential if environments are supportive of their health needs and if services are provided in a non-discriminatory manner. Much focus has been placed on the high HIV prevalence among women and youth in South Africa. Yet, international and local evidence shows that men who have sex with men (MSM), transgender people, sex workers (SW), injecting drug users (IDU), prison populations and specific migrant groups* are disproportionately affected by HIV and in many circumstances are marginalised by society. These key populations are the focus of this report. Research has shown that by reducing the HIV incidence within key populations, a reduction in incident HIV infections in the general population can be achieved. The HIV epidemic cannot be fully addressed without consideration of the needs and current gaps in the service, research, and support for key populations within South Africa.

In June 2011, South Africa signed the United Nations ‘Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS’, which explicitly outlined commitment for all UN member states to address the inadequacy of HIV prevention strategies, focusing on men who have sex with men (MSM), injecting drug users (IDU) and sex workers (SW) and to improve access to HIV prevention, treatment, care and support services for migrant populations.

Gap Analysis Methodology

This document provides an overview of the situation pertaining to these populations, inclusive of key issues affecting their vulnerability to HIV as identified by the literature and expert opinion, and provides prioritised recommendations for consideration at the next South African National Strategic Plan on HIV/AIDS, TB and STIs (NSP 2012–2016). A thorough data collection and consultation process was undertaken from November 2010–July 2011. This process involved a comprehensive review of published and grey literature, obtained through searches of databases and direct author contact. An extensive network of representatives from research, governmental, civil society and other sectors were engaged during all stages of this project. Stakeholders were contacted electronically, telephonically and in person. Data from the literature was integrated with key informant feedback to develop recommendations targeting key populations in South Africa’s HIV response. Additionally, participation by the authors in strategic local and national conferences and workshops enriched the understanding of the contextual factors pertaining to key populations, HIV and South Africa’s response. Provincial and national consultations were undertaken in order to provide an opportunity for review of findings of the consolidated process and to obtain consensus on the recommendations to be forwarded to the SANAC secretariat for consideration for inclusion in the NSP 2012–2016. Stakeholders were provided with an opportunity to review and comment on the document before its final publication.

The current climate for each population was assessed through the analysis of current strengths, weaknesses, opportunities and challenges (SWOC) in respect to the legal framework, policy, research, programming and funding for each key population.

* The situations and environments in which some migrants may exist increases their vulnerability to HIV, not being a migrant per se.
Key Populations and HIV in South Africa

Men who have sex with men (MSM), transgender people, sex workers (SW), injecting drug users (IDU), prisoners and migrant populations exist across South Africa and are in need of appropriate HIV prevention, treatment, care and support services. The importance of addressing gender inequality, discrimination and other inequities as well as providing tailored HIV interventions is highlighted. Overall, there is limited data available to assist in fully understanding the size of most of these populations in South Africa and the impact that HIV has within these populations.

This report refers to key populations at higher risk for HIV exposure. They include sex workers, people who inject drugs, men who have sex with men (MSM), transgender persons, people who inject drugs, sex workers and their clients are at higher risk of HIV exposure to HIV than other people and require specific focus within the national HIV and AIDS response. Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV. Key populations at higher risk for HIV infection are often subjected to stigma and discrimination and lack access to appropriate health services.

This document outlines key gaps and required responses to the key populations at higher risk for HIV infection as described above. However, noting the United Nations General Assembly Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS (2011), countries are encouraged to define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

We hope that this document will further assist in defining key populations that require specific focus and detailed attention in the national HIV and AIDS response.

HIV Epidemiology

Initial research conducted locally has highlighted high HIV prevalence among men who have sex with men (MSM), injecting drug users (IDU), sex workers (SW), migrant populations and prisoners, and has identified multiple barriers that limit access to HIV prevention, treatment, care and support services among all of the key populations mentioned. Several influences have been associated with increased vulnerability to HIV among individuals from these populations, and can be broadly classified as structural, social or individual risk factors. Despite the absence of population size estimates, preliminary evidence shows the existence of men who have sex with men (MSM), TG, injecting drug users (IDU) and sex worker (SW) populations across the country. Historical data confirms the role of internal and cross-border migration within South Africa. Correctional services data provides an accurate reflection of the number of recorded prisoners. HIV prevalence has been shown to range between 10 and 44%, 17 and 60%, and 3 and 27% among South African men who have sex with men (MSM), sex workers (SW), injecting drug users (IDU) and prisoners respectively. Whilst estimates of HIV prevalence for migrant groups is lacking, a recent study that targeted migrant farm labourers found that between 38 and 60% of participants were cross border migrants, where HIV prevalence was documented to be 28–49%.

Most research studies have utilised convenience sampling methods and have recruited individuals from major urban areas. Despite limitations in the research methodology, apparent trends in the data show disproportionate risk to HIV infection due to structural and societal influences and high-risk behaviours among these populations.

Legal and Policy Framework

The effectiveness of interventions aimed at addressing vulnerability to HIV among sex workers (SW) and injecting drug users (IDU) is limited by legislation, which criminalises sex work and drug possession, use and selling. Several South African laws are in direct contradiction to the rights provided by the South African Constitution, specifically those allowing access to justice and health services. Decriminalisation of sex work has been explicitly supported by the current National Strategic Plan (NSP) and after four years the appropriate legal reform still needs to occur. Current policy does not explicitly allow for the provision of needle syringe exchange (NSE) and opioid substitution...
Executive Summary

Therapy (OST) programmes as part of a holistic prevention package for injecting drug users (IDU). Punitive laws and limited prevention services have been suggested to be associated with high HIV prevalence among injecting drug users (IDU). Policies and programmes need to include NSE and OST within a package of services for injecting drug users (IDU), as part of the nine injecting drug users (IDU) interventions recommended by the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), and the WHO and UNODC target-setting guide should be used to steer the implementation and monitoring thereof. In addition, whilst we acknowledge that various pieces of legislation do exist to ensure that cross-border migrant groups are able to access HIV prevention and treatment, research findings clearly indicate that cross-border migrant groups face a range of challenges in accessing services. Migrants with pending legal status or outstanding documentation may not be able to access relevant services.

Key Population Representation and Advocacy

Apart from the South African National AIDS Council’s (SANAC) Lesbian Gay Bisexual Transgender and Intersex (LGBTI) and Women’s sectors, most key population advocacy issues and representations are headed by non-governmental organisations (NGOs).

Insensitive Health and Security Services

Across all groups, discrimination by service providers has been cited as a major barrier to accessing health, justice and safety services. Sensitisation training around key populations is required by all service providers, with additional training to further equip health professionals. No national programmes for key populations exist with most services being provided by non-governmental organisations (NGOs) and other for-profit private sector organisations. Violence inflicted on sex workers (SW) by police has been documented and needs to be prevented. Research indicates that there is a need for healthcare providers – particularly frontline staff – to be skilled in appropriate languages to cater for all migrant groups. This includes addressing the language needs of both South African and cross-border migrant groups.

Programming

Reports from key population representatives, researchers and advocates have highlighted that despite the guidance provided by the National Strategic Plan (NSP) 2007–2011, and its inclusion of men who have sex with men (MSM), injecting drug users (IDU), sex workers (SW) and migrants as populations requiring specific attention, little progress has been made in the achievement of targets set for these groups. The provision of services to key populations has been accomplished by non-governmental organisations (NGOs) with limited support from government structures. HIV interventions present within correctional services appear to be disjointed and in need of strengthening to provide appropriate and comprehensive services. There appears to be limited capacity to extend coverage of services as a result of limited funding.

The World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the Office of the U.S. Global AIDS Coordinator (OGAC) and the Southern African HIV Clinicians Society have developed recommendations and guidelines for standard HIV care and prevention. Tailored services in addition to the provision of a minimum package of services should be offered for specific key populations in areas of high vulnerability and demand. Guidelines exist for the recommended components of such a package for injecting drug users (IDU), prisoners, men who have sex with men (MSM), transgender people and for HIV prevention and sexually transmitted infections (STI) management among sex workers (SW) and populations in transition. A careful process aimed at integrating health services and NGO activities for key populations is needed.

Minimum Service Package

Access to non-discriminatory health services is a constitutional right that must be upheld, and needs to form part of all service provision packages. A minimum package of HIV prevention services should be inclusive of peer-based outreach activities: appropriate messaging (information, education and communication (IEC) materials); condoms and condom-compatible lubrication; voluntary and confidential HIV counselling and testing (VCT) services; and access to treatment if required. This package should be available to all key populations, regardless of legal status or documentation status.
testing (VCT) and referral for treatment with anti-retroviral therapy (ART); sexually transmitted infections (STI) and tuberculosis (TB) screening and referral for HIV, sexually transmitted infections (STI), tuberculosis (TB) treatment, care and support.

Referral for post-exposure prophylaxis (PEP) for HIV and other sexually transmitted infections (STIs), substance abuse and mental health services, and reproductive health services, including family planning and Pap smears should also be accessible.

**Extended Service Package**

Additional services particular to each key population are also required and should be provided where the concentration of these individuals is greatest – inclusive of risk-reduction strategies including opioid substitution therapy (OST) and needle syringe exchange (NSE) for injecting drug users; increased access to justice services and post-exposure prophylaxis (PEP) for sex workers. Consideration for the provision of pre-exposure prophylaxis (PrEP) for high-risk individuals should be made. The expansion of hepatitis A and B screening and vaccination and testing for hepatitis C should be considered for men who have sex with men (MSM) and injecting drug users (IDU).

In order to appropriately manage the overall HIV epidemic, the South African government, civil society and individuals must not only consider HIV within the general population but also develop targeted programmes which address the needs of the key populations. The development of the National Strategic Plan (NSP) for HIV/AIDS, STIs and TB (2012 - 2016) should be informed by data and reflect the successes and lessons learnt over the previous five years, most importantly the explicit inclusion of key populations is required to enhance the impact of the NSP on HIV in South Africa. Key population recommendations which are clear, achievable, realistic, sustainable and evidence-informed will be costed and submitted to the highest level of the South African National AIDS Council (SANAC) for consideration for final inclusion in the National Strategic Plan (NSP).
Key Messages

By investing in the specific sexual and reproductive health needs of key populations at increased risk of HIV acquisition, the number of new infections would be reduced enormously.

Punitive laws and legislation that do not facilitate public health and human rights-based approaches, limit the ability of national HIV responses to meet the needs of key populations.

A lack of adequate services, in addition to several social and structural barriers, including stigma and discrimination, have significantly contributed to the disproportionate HIV prevalence present among key populations in South Africa.

As a lead country in the current human rights declaration on HIV/AIDS, developed at the June 2011 UN General Assembly, South Africa has committed to addressing discrimination and its relation to HIV.

Additional research is required to assess national sample-size estimates of injecting drug users (IDU) and the link to HIV, and national HIV prevalence data on all key population groups and on sexual violence, consensual sexual practices, drug use and HIV prevalence within the prison system also requires additional research.

South African legal frameworks and policies support men who have sex with men (MSM) and migrants, but legal reform on sex work is still needed and policy reform around injecting drug user (IDU) interventions is required.

Key Populations in General

- To date, no national programmes exist within the South African HIV response to address HIV prevention, treatment, care and support the needs of key populations.
- Limited focused services and barriers to accessing existing services have contributed to the increasing number of HIV infections among key populations.
- Men who have sex with men (MSM), transgender people, injecting drug users (IDU), sex workers (SW), migrants and prisoners continue to be at increased vulnerability to HIV infection and, in order to reduce new HIV infections in South Africa, interventions tailored to the needs of key populations are an essential part of an effective response.
- Initial studies have confirmed high HIV prevalence among key populations in South Africa and several socio-economic factors, including poverty and marginalisation, are associated with increased vulnerability to HIV among these populations.
- South Africa reaffirmed its commitment to addressing human rights violations based on discrimination at the June 2011 UN General Assembly meeting.
- South Africa did not reach any of its National Strategic Plan (NSP) targets for key populations, and provided limited data on key populations for the 2010 United Nations General Assembly Special Session (UNGASS).
- Evidence of discrimination towards individuals from key populations by health care workers and other service providers has been identified and is a major barrier to the accessing of public health services.
- No accurate South African population estimates for these populations exist.
- Targeted HIV programming that takes into consideration the societal, structural and individualised barriers facing key populations is needed.
- Interventions addressing the specific needs of key populations have shown to be effective in reducing HIV incidence in the general population.
- A comprehensive monitoring and evaluation framework which allows for the monitoring of interventions and progress is needed to ensure that the government takes ownership of interventions and the data pertaining to HIV responses.
A minimum service package for all key population groups should include:

- Access to non-discriminatory and quality health care services;
- Peer-based outreach activities;
- Provision of appropriate information, education and communication material;
- Provision of male and female condoms and condom-compatible lubrication;
- Voluntary and confidential HIV counselling and testing (VCT);
- Sexually transmitted infections (STI) and tuberculosis (TB) screening; and
- Referral for sensitive provision of: HIV, sexually transmitted infections (STI) and tuberculosis (TB) treatment, care and support; substance abuse and mental health services; post-exposure prophylaxis (PEP) and reproductive health services, including family planning, termination of pregnancy and cervical cancer screening programmes.

An extended service package of care should include:

- Minimum services, plus services particular to the individual including, but not limited to, access to male circumcision; substance abuse risk-reduction programmes and potential pre-exposure prophylaxis (PrEP).

**Men Who Have Sex with Men (MSM)**

- Research has shown men who have sex with men (MSM) in South Africa to have an HIV prevalence of 10–43%, that is more than double the prevalence of men in the general population.
- Most men who have sex with men (MSM) studies have utilised respondent-driven or opportunistic sampling methods that may not provide data that is representative to the broader men who have sex with men (MSM) population.
- The inclusion of mainly gay-identified and younger men who have sex with men (MSM) may underestimate the prevalence of HIV among men who have sex with men (MSM).
- No government supported national men who have sex with men (MSM) programme exists.
- Despite a supportive legal environment, men who have sex with men (MSM) experience discrimination and stigma, limited men who have sex with men (MSM)-sensitive services, and socio-economic barriers to accessing care.
- High-risk sexual behaviours, limited knowledge around HIV and substance abuse have been identified as individual factors for HIV acquisition among men who have sex with men (MSM).
- High-risk sexual behaviours have been identified in some men who have sex with men (MSM), including unprotected anal intercourse, multiple sexual partners and sex work.
- Condoms and lubricants are not accessible to many men who have sex with men (MSM).
- Comprehensive men who have sex with men (MSM) programming needs to include mental health, substance use and sexual and reproductive health services.
- Access to pre-exposure prophylaxis (PrEP) should be considered for high-risk HIV-negative men who have sex with men (MSM).*

**Transgender People**

- Transgender people consist of a wide spectrum of individuals with diverse sexual practices, preferences and identities.
- Policy makers and programme developers should recognise that transgender women are distinct from men who have sex with men (MSM).

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* Guidelines for the use of PrEP in South Africa are under development. High-risk men who have sex with men (MSM) would include, but not be limited to, those presenting a sexually transmitted infection (STI), those with an HIV infected partner, those with multiple partners, those who are unable to use condoms and sex workers.
Interventions aimed at men who have sex with men (MSM) do not automatically address the needs of transwomen*, and nor do those directed at women who have sex with women (WSW) address the needs of transmen**.

Transition of bodily appearance may occur in stages and transgender individuals may lie on a continuum of transition.

The Alteration of Sex Description and Sex Status Act No. 49 of 2003 allows for individuals to legally change their gender, provides for those who are in various stages of transition, and is not limited to those who have undergone reassignment surgery.

Only two South African public specialist centres provide gender reassignment surgery, and these do not meet the demand.

The health needs of transgender people are unique and are rarely addressed and, in addition to physical, mental and sexual health services, require specialised services which are not limited to hormone therapy and gender reassignment surgery.

Marginalisation of transgender people and barriers to accessing employment result in higher rates of sex work and unemployment among transgender people.

Sexual violence and rape are key issues facing transgender people.

Active representation and participation by transgender people on Lesbian Gay Bisexual Transgender and Intersex (LGBTI) forums and other platforms should be ensured to allow for gender identity to be appropriately acknowledged, and transgender people will be empowered with the right to self-determination.

Transgender people have been excluded from research because of pervasive stigmatisation, denial and the hidden nature of some transgender people.

Programmes should make provision for gender identity and cater for the needs of transgender people.

Injecting Drug Users (IDU)

The number of people who use drugs, including injecting drug users (IDU), is growing in Africa.

The proportion of heroin-related drug treatment admissions in South Africa is increasing.

The risk of HIV infection through injections is six times greater than that of unprotected penile-vaginal sex, and the risk of hepatitis C virus (HCV) transmission is even higher.

The use of contaminated needles is the major risk factor for HIV and hepatitis C virus (HCV) spreading among injecting drug users (IDU).

Health facilities in South Africa do not provide access to needles and syringes for injecting drug users (IDU).

Limited knowledge of HIV risks associated with injecting drug use and barriers to accessing clean needles increase the use of contaminated needles.

A ‘harm reduction philosophy’ encompasses a holistic approach to the prevention and treatment of drug use and the prevention of complications of drug practices, including HIV, hepatitis C (HCV) and other medical conditions.

Needle syringe exchange (NSE) and opioid substitution therapy (OST) programmes have been shown to decrease the frequency of HIV infections and needle sharing, as well as lower morbidity and mortality among injecting drug users (IDU), and should be included in national drug policy, with sufficient funding and the support of law enforcement agencies.

Countries that have introduced drug policies that included a ‘harm reduction’ philosophy have improved health outcomes of people who use drugs and have not experienced an increase in drug taking behaviour.

The World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), UNAIDS and Office of the US Global AIDS Coordinator (OGAC) guidelines

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* A transwoman begins life with a male body but identifies as female.
** A transman begins life with a female body but identifies as male.
support integrated approaches which include needle syringe exchange (NSE) and opioid substitution therapy (OST) programmes, using a nine step intervention approach.

- In South Africa there is a continued focus on ABC programmes despite evidence to support the effectiveness of needle syringe exchange (NSE) and opioid substitution therapy (OST).
- The quality of rehabilitation and aftercare programmes for injecting drug users (IDU) is very poor.
- South African guidelines for the treatment of heroin and opiate dependence are not currently available and the accreditation of practitioners (mental health and health) and treatment facilities needs to be enforced and monitored in order to ensure that evidence-informed, standardised care is provided.
- Drug use has been linked with poverty and lack of opportunities, and through addressing broader social issues substance abuse interventions may be more effective.

Sex Workers (SW)

- The ongoing criminalisation of sex work undermines several constitutional rights.
- Criminalisation of sex work increases the overlapping vulnerabilities of sex workers (SW) including violence, abuse, harassment, HIV and lack of access to services and justice.
- Criminalisation of the clients of sex workers (SW) may result in further increases in vulnerability of sex workers (SW) to HIV and impact on public health.
- Discrimination towards sex workers (SW) by society compound the stigma attached to sex work.
- Decriminalisation of sex work is required to ensure the constitutional rights of sex workers (SW) are protected.
- Decriminalisation of sex work is in line with a public health approach to ensuring access to health care.
- Protection of sex workers (SW) under labour law will mitigate unsafe working conditions and empower sex workers (SW).
- Capacity building of sex workers (SW) is required in order for them to exercise their rights and access to justice.
- Pilot outreach activities focusing on sex workers (SW) in South Africa have demonstrated success in improving sex worker (SW) access to HIV testing, treatment and support services, and are models which could be used for national roll-out to increase coverage.
- Insensitive health services lead to sex workers (SW) avoiding health facilities or use of private facilities where affordable.
- Some donor restrictions, most notably the President’s Emergency Plan for AIDS Relief (PEPFAR), on sex work programme activities limit the breadth and range of organisations working with sex workers (SW), and their services.

Prison Populations

- South Africa has the highest proportion of prisoners in southern Africa.
- Many offenders cycle in and out of correctional service facilities and other secure facilities of the criminal justice system.
- Initial research has identified disproportionately higher levels of HIV among prisoners compared to the general population.
- Violence, particularly sexual violence, and drug use is under-reported in prisons.
- Globally injecting drug use (IDU) practices are high within correctional institutions.
- Condoms are irregularly available within the prison system.
- Condom-compatible lubrication is not provided and should be.
- Prisoners are at risk of sexual assault and some may engage in consensual sex and may take drugs. Services should be tailored so as
to addresses the HIV risks of these practices within correctional centres.

- A shortage of doctors and other health care professionals within the correctional service system limits its ability to provide quality and coverage of services.
-Awaiting-trial detainees are in greatest need of improved HIV prevention and sexual and reproductive health services.
- Accurate data around drug use, sex between men and other sexual practices is needed in order to improve services within the prison system.
- Overcrowding in prisons facilitates the transmission of communicable diseases.
- Funding for HIV interventions is currently limited.
- Stigma and discrimination by prisoners and prison staff around HIV, drug use and sex between men is not appropriately addressed.
- Historically there has been little attention from the Department of Correctional Services (DCS) on preventing sexual violence and the department currently lacks a comprehensive framework for dealing with the problem.

Migrant Populations

- Migration is a global reality and is an important contributor to development in southern Africa.
- Locally, migration involves the movement of people within South Africa and, to a lesser extent, the movement of people across borders. Approximately 3% of the South African population is estimated to be cross-border migrants, reflecting global trends.
- The conditions associated with migration affect vulnerability to HIV, not being a migrant per se.
- Some migrant groups are concentrated in ‘spaces of vulnerability’ – geographic locations where the context increases vulnerability to HIV – including farms that rely on migrant labour and urban informal settlements. The highest HIV prevalence nationally is found in urban informal settlements.
- A place-based approach to migration and HIV is required, which focuses on ‘spaces of vulnerability’ – including locations where migrants exist and may interact with local communities in environments conducive to higher-risk sex or multiple concurrent partnerships.
- ‘Spaces of vulnerability’ are not limited to border posts, ports, mines, farms and peri-urban informal settlements.
- Combination HIV prevention interventions should be implemented in identified ‘spaces of vulnerability’, which also increase access to health services for local and migrant populations.
- Existing legal frameworks and policies that ensure the right to access HIV prevention, treatment and services for all migrant groups need to be implemented and monitored. Existing legislation is not effectively implemented.
- Appropriate policy exists in South Africa to ensure that all migrant groups have the right to access HIV prevention and treatment services, but dissemination, implementation and monitoring of these policies is required.
- Synergy between countries of the Southern African Development Community (SADC) is necessary to maximise the health of migrants.
South Africa remains the epicentre of the global HIV pandemic. Within South Africa there are many populations that are uniquely affected by HIV and whose specific health care needs are not appropriately addressed in South Africa’s current HIV response. Many of these individuals remain on the periphery of society and face structural, social and individual risk factors that increase their vulnerability to, and the effect of, HIV.

Collectively referred to as ‘key populations’, men who have sex with men (MSM), injecting drug users (IDU), sex workers (SW), specific migrant sub-groups, prisoners and transgender people are part of every community in South Africa and are in urgent need of support, equal access to care, and protection from the stigma and discrimination that leads to their increased vulnerability to HIV.

Unfortunately, the realities faced by many key populations in South Africa are often hidden, under-represented, or otherwise left out of broader discussions relating to HIV. To the knowledge of the authors, this report is the first consolidation of information pertaining to key populations in South Africa. It is meant to highlight the needs and burdens of some of South Africa’s most vulnerable populations and has been designed for a wide range of readers. Especially policy makers, service providers, researchers and community members should use this report as an advocacy tool, informational resource and support document.

In order for South Africa to increase the effectiveness of interventions aimed at preventing new infections, lessening the impact HIV and AIDS has on communities and in increasing access to HIV prevention, treatment, care and support services, the needs of key populations must be acknowledged, addressed and taken into consideration during all stages of the development of the National Strategic Plan (NSP) for HIV/AIDS, STIs and TB (2012–2016).

In order for effective recommendations to be made and implemented a better understanding of the current situation for key populations is needed. It is for this reason that this gap analysis was undertaken. This document is a review of the current state of knowledge, service provision, laws and policy pertaining to key populations in South Africa. Furthermore, it includes recommendations to address current knowledge and service gaps and address barriers to accessing HIV prevention, treatment, care and support among key populations.

This report also represents feedback and input from a broad range of stakeholders and incorporates findings from scientific literature. It is meant to be reflective of current data and experience, and all efforts were made to appropriately acknowledge and cite referenced work.

This report was made possible through support from the South African National AIDS Council (SANAC) and the South African UN Joint Team on HIV & AIDS and Irish Aid.
II. Aims and Objectives

The aim of this document is to facilitate the development of policy, strategies, interventions and actions that will address the current gaps in research and services pertaining to the response to HIV for MSM, transgender people, IDU and SW and HIV in South Africa, with specific emphasis on: 1) policy development; 2) policy implementation; 3) recommendations for programmatic development and implementation and; 4) monitoring of implementation, outputs and impact.

Objectives:
1. To conduct a review of global and local evidence around HIV epidemiology and effective HIV interventions focusing on key populations;
2. To analyse international guidelines on HIV prevention, treatment, care and support among key populations and assess South Africa’s performance;
3. To review the current NSP as it pertains to MSM, IDU and SW and migrants, and to assess progress towards achieving stated objectives and gaps in planning;
4. To develop consensus on recommendations to address disparities in knowledge, strategic information services and support provision, appropriate to the local context and available resources for key populations; and
5. To incorporate resulting legal, policy and programming recommendations into the development of the NSP 2012–2016.
III. Methodology

Brief Overview

This report was developed using multiple methods in consultation with key stakeholders. A literature review, complemented by key informant feedback and broad stakeholder consultations, was undertaken as part of this gap analysis. Considerable effort was placed on sourcing information from various locations, and on engaging relevant stakeholders during all stages of project planning and implementation.

The findings of the gap analysis and consultation process were translated into prioritised recommendations for national HIV strategic planning purposes. The costed recommendations will be forwarded to SANAC for consideration for incorporation in the NSP 2012–2016. The methodology implemented in this project is summarised in figure 1.

Stakeholder Engagement

In order to build support for this process and obtain input from relevant sectors and role players, comprehensive stakeholder engagement activities were initiated before commencing the literature review. Representatives from key populations as well as individuals and organisations representing civil society, SANAC structures, government departments, academic institutions and development partners with expertise in working with MSM, transgender people, IDU, SW, prisoners and migrants, were contacted. Thereafter, engagement was extended through the networks of these initial stakeholders and their contacts.

An introductory email was sent out to contacts providing an overview of the proposed project, including its aims and objectives. Key informant interviews were conducted among representatives

Figure 1: Gap analysis methodology

- Stakeholder engagement
  - Literature review
    - Key informant feedback
      - Stakeholder consultation
        - Regional workshops
          - National workshops
            - Consolidation of data

- Stakeholders identified
  - Electronic contact (165)
    - Telephonic interviews (12)
      - Face-to-face interviews (6)

- Review of peer reviewed articles, grey literature, international guidelines and SANAC progress (>240 documents)

- Electronic feedback of key population template (150 sent out, 21% response rate)
  - Workshop participation

- Pretoria workshop (60 participants)
  - Cape Town workshop (41 participants)

- SA AIDS conference workshop (72 participants)
from relevant key populations. A request was made for information on their experience in working with key populations, as well as for published and grey data for inclusion in the gap analysis. A contact database was developed and was used to communicate progress, obtain input and to be used for information dissemination. Key informant interviews were conducted among targeted representatives in order to obtain an in-depth understanding of key populations and HIV in South Africa.

In total 165 individuals and organisations were identified and contacted electronically. Of the 165 contacts 12 teleconferences and six face-to-face semi-structured interviews were conducted.

Literature Review

Published experience and findings of research, policy analysis and programming conducted among key populations in South Africa were identified and analysed using an analytical framework. The outcome of the literature review was the development of an initial set of recommendations focusing on key populations to be refined through stakeholder consultation.

Original, review and opinion data pertaining to MSM, transgender people, IDU, SW, prisoners, migrants and HIV in South Africa were eligible for inclusion in the literature review. Data from Africa and beyond was included in the review, where appropriate. Data sources ranged from journal articles, reports, publications and conference proceedings to briefing notes. Published data was accessed using online databases (PubMed, Medline and Google Scholar). Grey literature was sourced through web searches and direct author and organisation contacts. International guidelines and recommendations for policy, programming and research for key populations were collected through online searches and through direct communication with international development partners and agencies and experts.

Overall, 247 relevant articles (5 key populations, 66 MSM, 5 transgender, 57 IDU, 77 SW, 17 prisoners, 6 migrants, 6 HIV epidemiology, 8 policy and NSP-related) were reviewed, analysed and utilised.

Review of nation planning documents and international guidelines

The NSP 2007–2011, the mid-term review of the NSP 2007–2011, the South African Country Progress Report on the Declaration of Commitment on HIV/AIDS 2010 report, the National Composite Policy Index reports, and international guidelines and recommended practice for HIV prevention, treatment, support and care for key populations, including those from UN agencies, OGAC, The Global Fund and others, were analysed in order to inform recommendations development during this process.

Key Informant Feedback

Electronic key informant feedback

The stakeholders and partners who participated in the earlier phases of the projects were contacted directly and requested to provide input on the NSP as it pertains to key populations. Collection of data and the synthesis of expert opinion and recommendations were achieved using a standardised template. Details about the representative or organisation providing feedback, experience in providing services to key populations and published documents and tools were captured, as well as commentary and opinion on the current NSP and proposed improvements for the next NSP. The template was sent out electronically and data obtained was analysed using key theme analysis.

One hundred and fifty requests for feedback were sent out electronically. Twenty one per cent of templates were returned (32/150). Upon subsequent interaction with stakeholders, and upon observation of other gap analysis activities, the poor response rate was attributed to questionnaire fatigue and limited capacity of staff and time available to allocate resources to complete the template. Preferred methods for solicitation of feedback included the use of focus group methodology.

Workshop participation

The authors participated in several workshops and conferences in order to increase their depth of understanding regarding the issues affecting key populations, and to strengthen networks and obtain input on the development of recommendations.
Sex Worker Decriminalisation Workshop
Hosted by Sisonke and the Sex Worker Education and Advocacy Taskforce (SWEAT) in Cape Town on 20–21 January 2011, the workshop provided an opportunity for the provision of updates on Sisonke activities throughout South Africa; the establishment of the South African chapter of the African Sex Worker Alliance (ASWA), and an update of the work done by the Sex Worker Decriminalisation Working Group. Discussions were held around key challenges facing SW and the development of solutions and plans for addressing them. The workshop was attended by representatives from SW organisations, researchers, development partners and advocates from across South Africa as well as a representative from the SANAC Women’s Sector and the South African Police Service (SAPS).

SANAC Lesbian Gay Bisexual Transgender Intersex (LGBTI) Sector Meeting
The first meeting of the SANAC LGBTI Sector was held in Cape Town on 3–4 March 2011, providing an opportunity for LGBTI organisations, national government, the Joint UN Team on AIDS, SANAC and other development partners to participate in strengthening the representation of the LGBTI community within SANAC structures and the national HIV response. In addition to an overview of HIV epidemiology and current service provision targeting LGBTI, the draft LGBTI programme to achieve the NSP 2007–2011 targets was presented. Small group discussions and work shopping provided the opportunity for improvement of the recommendations and establishment of an LGBTI working group.

UNAIDS Regional Civil Society Consultation on Universal Access
The Desmond Tutu HIV Foundation gave a presentation entitled ‘National Ownership & Universal Access – the need for inclusion of key populations’ at the UNAIDS civil society consultation on Universal Access held in Johannesburg on 10–11 March 2011. An overview of the issues facing key populations and the high HIV prevalence among these populations across Africa was used to introduce the rationale for including key populations in national HIV responses. The current gap analysis was used as a case study of how civil society representation, combined with key population and government engagement could be used to improve HIV strategic planning.

Consultations
The resulting recommendations from the literature review, review of country progress, international recommendations and key informant feedback processes were summarised into a document which was circulated among stakeholders for review prior to consultation sessions.

Invitations to participate in the consultation process were extended beyond the stakeholders initially involved in the literature review and feedback processes. The consultation process involved regional and national workshops which were hosted by the SANAC secretariat and facilitated by the implementing partners. At the consultations representatives from key populations, civil society, research organisations, government and development partners were invited to present their experiences of working with key populations as well as their opinions regarding strategic planning to improve the effectiveness of HIV prevention, treatment, care and support interventions among key populations. Overall, 173 participants partook in the consultation sessions, with 101 people taking part in the provincial consultations (60% in Pretoria and 40% in Cape Town) and 72% in the national consultation. Of the participants 36% represented key population and advocacy organisations; 26% represented research institutions, 20% service providers and 18% government structures. Good attendance at these sessions highlighted receptive attitudes towards increasing efforts directed at key populations, and the broad scope of representation was an indication of existing local capacity to address identified gaps in knowledge, and to inform best practice and roll-out interventions in the presence of appropriate funding.

Provincial consultations
In order to obtain geographic representation and maximise participation in the development and representativeness of the recommendations, stakeholder workshops were held on 16–17 May 2011 at the SANAC offices in Pretoria, and on 19–20 May 2011 at the University of Cape Town.

Invitations to participate were sent electronically to pre-identified stakeholders five weeks in advance of the workshops. Electronic follow-up using reminder
emails were sent one week prior to the workshops. Additional contact was made with stakeholders who had not confirmed attendance, and invitations were extended to additional contacts as the need arose. Particular attention was made to invite representatives from government departments using established links through the Joint UN Team on HIV and AIDS. Telephonic follow-up to confirm receipt of invitation and participation was used as needed. An electronic summary of the findings and recommendations of the literature review and key informant feedback were provided a week before the workshop in order for stakeholders to prepare feedback and review for the workshop sessions.

Welcomes and overviews of the issues facing key populations in South Africa, as well the process for the development of the upcoming NSP were provided by representatives from SANAC and UNAIDS. An overview of the gap analysis methodology was provided by the DTHF. Representatives from organisations involved in the gap analysis presented information around HIV epidemiology, framed key populations within the current NSP and the response to date, and provided an overview of the NSP recommendations for key populations. Smaller break-out groups were formed to workshop suggestions for the improvement and refinement of NSP recommendations, and were presented to workshop participants. Voting on priority recommendations within the NSP priority areas for each population was undertaken. The integrated prioritised recommendations were then circulated for final comment in preparation for national level consultation.

National consultations
A national consultation around key population recommendations was hosted by the SANAC secretariat in Durban on 8 June 2011, coinciding with the 5th SA AIDS Conference. During this satellite session a brief overview of the gap analysis and recommendation development process was provided by a range of stakeholders involved in the processes to date. The refined recommendations were also presented for further comment. During the question and answer sessions, the importance of further refinement of the recommendations and increased engagement around prison populations were emphasised.

Outputs of this Gap Analysis Process

- A document providing a summary of the findings of a thorough review of current data on key populations and HIV in South Africa;
- An overview of South Africa’s programmatic response to HIV among key populations, and progress towards reaching stated goals and commitments;
- The development of a network of organisations and individuals committed to the needs of key populations in South Africa;
- A policy brief around key populations and HIV in South Africa to be used as an advocacy and education tool;
- The development of a set of recommendations which reflect the priorities of key populations, to inform the development of provincial and national strategic plans on HIV, AIDS, TB and STIs; and
- Dissemination of findings among general and scientific communities through presentations at conferences and the publication of a peer reviewed article.
An Introduction to Key Populations

Globally, MSM, transgender people, SW, IDU, prisoners and migrant populations have been shown to be at disproportionate risk for HIV infection. Broadly speaking, the international HIV response has not adequately provided services that address the needs of these groups, and as a result the HIV epidemic continues to have a dramatic impact within the contexts of key populations. These ‘key populations’ form part of the general population, have many overlapping needs and concerns and, while they are not epidemiologically separated, they do have a unique impact on both concentrated and generalised HIV epidemics and most importantly their inclusion in HIV interventions can improve the global impact of HIV responses. South Africa joined other members of the United Nations in declaring political support to address stigma and discrimination facing key populations as part of efforts to eliminate HIV and AIDS.

National efforts to address HIV among MSM, IDU and SW are monitored through the UNAIDS country reporting process (UNGASS). There are large gaps in data, which in many cases reflect a lack of programmes for these communities as well as poor coordinating, monitoring and evaluation structures where services do exist. A positive sign is the improvements in reporting on certain key populations within the African region, yet many African countries still do not provide any information on interventions for MSM, IDU and SW. In 2010 the median HIV prevalence among SW from countries submitting data was 3% (range 0–40%); among MSM was 6% (0–35%) and among IDU 8% (0–62%). See figure 2.

HIV prevalence within these groups tends to be higher in areas where same-sex behaviours, drug

Figure 2. Global HIV prevalence among SW, MSM and IDU as per 2010 Country Progress Reports (median and ranges*)

*Methodology may vary for individual countries. Data reported to UNAIDS in 2010 but dates of data collection may vary.
use and sex work are criminalised, and where appropriate interventions addressing the health needs of prisoners and migrants are absent. High levels of prejudice and moral loading in the absence of criminalisation of behaviours has also been shown to facilitate the spread of HIV and develop barriers to accessing prevention, treatment, care and support services. Whereas the uptake, access and utilisation of services focusing on key populations is significantly better within enabling environments where non-discriminatory services are provided.

Countries that have laws, regulations or policies in place which prevent individuals from accessing HIV services further marginalise and disempower these individuals and communities. Laws which may not specifically be intended to prevent key populations from accessing health services may result in key populations being prosecuted or discriminated against should they access health services. Legal frameworks that are not complementary to advancing HIV policies and focus areas undermine the effectiveness of HIV prevention, treatment and care programmes. Health care workers may face prosecution for providing services to these individuals where sex work, same-sex behaviour and drug use is illegal.

Insufficient Support for Key Populations

Globally, health services tailored to the needs of key populations are limited. In North America and Europe HIV is concentrated within MSM and IDU populations and in response, appropriately focused services have been implemented, but barriers exist to the expansion of such services, even within these regions. In South and Southeast Asia, interventions focusing on risk and harm reduction among SW and IDU have been implemented. There are however, still regions where HIV prevention, treatment, care and support for key populations do not exist. Parts of South America, the Caribbean, and various countries in Africa have yet to include programmes that benefit key populations in their national responses to HIV and AIDS.

Limited resources have been made available to specifically address HIV among key populations, despite evidence identifying disproportionate HIV burden and elevated risk among these individuals and their communities. Between 2002 and 2009 The Global Fund to Fight AIDS, Tuberculosis and Malaria only allocated 6% of its cumulative funding towards ‘most at risk populations’. Of the Round 8 grant money, 9% targeted MSM, SW and IDU (US$79 154 825). The major focus of this spending was towards HIV prevention interventions and efforts to develop supportive environments. Out of the 9% allocated towards most at risk populations only 4% was designated for treatment.

The Sexual Orientation and Gender Identity strategy of the Global Fund was developed in 2007 in an attempt to encourage support of key populations, specifically MSM and transgender interventions. Additionally, funding categories for SW, IDU and prisoners is also available for countries which are awarded support based on successful proposals.

Of major concern is the existence of funding conditions that specifically limit or prevent support for key population focused interventions. Ideological-based funding requirements often have far-reaching effects on HIV and public health goals, and hamper progress in effective engagement with, and support of, key populations. For example, PEPFAR’s ‘Anti-prostitution Loyalty Oath’ makes funding conditional on PEPFAR recipients pledging that they will not advocate for the legalisation or decriminalisation of sex work. In effect, this requirement prevents organisations which support decriminalisation of sex work (based on human rights and public health grounds) from accessing PEPFAR funding. A recent ruling by a United States federal appeals court found that such a pledge could not be required of U.S. based organisations. To date this ruling has not been extended to non-U.S. organisations.

Currently there exists a global push to strengthen health systems and achieve Universal Access*. Health system strengthening is vital to improve health outcomes, however the resulting medicalisation of the epidemic may divert attention from the cultural and structural vulnerabilities and issues affecting key populations. Progress towards achieving Universal Access and the Millennium Development Goals (MDG) will be hampered if the HIV prevention, care, treatment and support needs

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* Universal Access relates to the provision of accessible, acceptable health services and financial risk protection to all, based on need and not ability to pay.
of key populations are not addressed and included as part of national responses to achieving Universal Access and the MDGs. In addition to the lack of constitutional protection, many policies and interventions are in place that have not been effective in supporting or have shown to be harmful towards key populations. For example, a review of evidence around the use of conversion or reparative therapy aimed at converting homosexual or bisexual individuals into heterosexuals highlighted a lack of biologic plausibility and efficacy data, and that such interventions are ethically controversial, ineffective and may in fact be harmful. Where OST and other components of harm reduction philosophy have not been included in national HIV responses, as in Russia, the spread of HIV among IDU has been rapid and resulted in large scale morbidity and mortality. Where the rights of SW are not protected, as in Cambodia, arbitrary arrest and detention, as well as physical and sexual abuse, including rape, extortion and bribery occur without those responsible for the crimes being held accountable. Increased and ongoing government and international support and funding of interventions focusing on key populations are needed. Funding conditions which prevent direct support of key population focused interventions should be removed and replaced with requirements aimed to ensure explicit support for interventions which focus on the needs of key populations. The fostering of enabling environments and the removal of other structural and social barriers to accessing HIV prevention, treatment and care services by individuals can be achieved through directed support and ultimately contribute to effective, comprehensive HIV responses.

Key Populations and HIV in South Africa

The HIV epidemic in South Africa is heterogeneous, with variability in HIV prevalence across geographical areas and among different sectors of the population. The largest proportion of individuals living with HIV are found around South Africa’s four major urban areas, with over half of those living with HIV residing in KwaZulu-Natal and Gauteng. Figures 3 and 4 provide a graphic representation of the distribution and number of individuals living with HIV across the country, per district. Additionally, HIV prevalence from national surveys have been shown to vary according to other demographic characteristics – with young, black women from urban informal settlements having the highest HIV prevalence. (SANAC, 2011b) It should be noted that such national surveys have not specifically included methods to accurately access hard to reach populations, for example IDU or SW and may not be appropriate methodology to enquire about same-sex behaviour or sex work. There is evidence to suggest that the overall prevalence of HIV among adults in South Africa is stabilising at around 17%, however, as the South African population continues to grow, the absolute number of individuals living with HIV in South Africa is estimated to increase by 100 000 every year. In 2009, 5.63 million South Africans were estimated to be living with HIV (figure 5). Preliminary findings of the South African government’s ongoing national HCT Campaign estimated the HIV prevalence in the general population in 2010 to be approximately 18%, (36) which supports the findings of the 2008 household survey conducted by the Human Sciences Research Council (HSRC) and the 2008 antenatal care survey which showed estimated HIV prevalence at 17% and 18% respectively. This is in contrast to the 25% estimated in the 2005 antenatal survey. National HIV responses appear to be having an impact on overall HIV prevalence, but concerns around the lack of interventions tailored to the needs of key populations, and failure to address the structural and social barriers which prevent key populations from accessing services are highlighted by the high proportion of new HIV infections estimated among SW, MSM and their partners (and where relevant, their clients), estimated to account for 9.9% and 20% of new infections in 2010 respectively. This data suggests that interventions to date have failed to address the specific needs of key populations and that attention should be paid to alter the national response accordingly. Epidemiological data on HIV among key populations is derived from multiple small studies, which have generally used opportunity-sampling methods and included only a small number of people. As a
Figure 3: Estimated density of people living with HIV in 2008.2

Figure 4: Estimated clustering of people with HIV in 2008.2
result, the external validity of the findings may have some limitation, but they do provide evidence of the existence of such populations across the country and illustrate disproportionate HIV prevalence compared to the general population. HIV prevalence among MSM has been documented as ranging from 10–50% among MSM, from 40–69% among SW, 19–41% among prisoners and 3–35% among IDU. Details of relevant studies and references are provided in the relevant sections of this report.

South Africa’s Response to Key Populations and HIV

NSP on HIV/AIDS, STIs and TB (2007–2011)

The national response to HIV and AIDS is guided by South Africa’s NSP for HIV/AIDS, STIs and TB. This document is intended to represent South Africa’s multi-sectoral approach to address HIV infection and the impact of AIDS. Data from surveillance and research activities, together with input from a variety of stakeholders are used to inform its development. The document outlines the nature of South Africa’s HIV epidemic and identifies socio-economic influences associated with increased vulnerability to HIV infection, and delineates links between HIV, TB and other infectious diseases. Additionally, it highlights the need to address social and economic realities which increase vulnerability among certain segments of society, and highlights the need to address stigma, denial, exclusion and discrimination which can be associated with HIV and AIDS.

Principles of gender equality and the explicit focus on youth, and a greater role for people living with HIV are included in the NSP (2007–2011). Effective communication and partnerships; the need to address social change, poverty and the role of personal responsibility were included as principles guiding South Africa’s response to HIV. The NSP (2007–2011) has four priority areas that include (1) prevention, (2) treatment, care and support, (3) research, monitoring and surveillance, and (4) human rights and access to justice.

MSM, transgender people, SW, IDU and non-citizen groups are explicitly mentioned within the NSP as
requiring interventions to address inequality and discrimination, as well as improved access to HIV prevention, treatment, care and support for these groups.

In addition to activities aimed at HIV prevention, treatment, care and support, the NSP identifies a range of interventions intended to improve access to justice and to facilitate law reform in order for the NSP’s goals and objectives to be reached. Recognition is made of the need to address social and economic realities that increase vulnerability among certain segments of society and to provide the tools and services required to prevent HIV infection and mitigate the effects of the HIV epidemic, as well as fostering an environment which will encourage and enable access to HIV testing and related services. Respect, promotion and realisation of human rights are outlined as fundamental components of all priority interventions.

The NSP clearly outlines support for the decriminalisation of sex work and includes several activities aimed at increasing access to HIV prevention interventions for MSM.

NSP Objectives and Targets Specifically Relating to Key Populations:

**Objective 2.5:** Increased roll-out of prevention programmes for higher risk populations (in prisons, among MSM, lesbians and transgender people and for SW and their clients)
- HIV prevention interventions within prisons were to include: VCT, condoms, lubricants, STI symptom recognition and access to PEP, STI management and TB screening. By 2011, 95% of correctional service facilities were due to have rolled-out comprehensive HIV prevention packages.
- HIV prevention packages for MSM, lesbians and transgender people were to include: VCT, condoms and STI recognition. Overall, 70% of relevant groups were to be covered by HIV prevention packages by 2011.
- HIV prevention interventions for SW were to include: dedicated VCT, condoms, STI symptom recognition and information on gender rights. By 2011, 95% of organised groups were to be covered by these services.

**Objective 2.8:** Develop and integrate interventions for recreational drug use in young people.
- One hundred public sector drug rehabilitation programmes were to be established by 2011.

**Objective 4.3:** Investigate the extent of HIV risk from IDU and develop policy to minimise risk of HIV transmission through injecting drug use and unsafe sexual practices.
- Continuous research and monitoring around IDU practices and links with HIV infection were due to occur on an annual basis;
- Policy and guidelines for HIV prevention among IDU were to be developed and reviewed annually; and
- By 2011, public sector rehabilitation programmes were due to be established in all provinces, according to provincial need.

**Objective 8.3:** Strengthen the implementation of policies and services for marginalised communities affected by HIV/AIDS
- By 2007 all districts were to promote integration and equitable representation of LGBTI people in care, treatment and support programmes.

**Objective 16.3:** Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalised groups.
- Information materials were due to be developed and distributed on rights to HIV prevention, treatment and support that respond to the special needs of SW, drug users, prisoners, MSM, gay and lesbian people, and refugees, undocumented migrants and immigrants. By 2011, 80% of organised groups were to be covered.38

**Assessing South Africa’s performance towards reaching commitments to key populations**

The compilation and analysis of stakeholder feedback and data from the NSP Mid-term Review (2010) and the South African Country Progress Report on the Declaration of Commitment on HIV and AIDS (2010) were used to assess progress towards meeting key population commitments.
Stakeholder Feedback

A standard template was sent out electronically to key population stakeholders to gather and analyse their opinions and experience around South Africa’s progress towards reaching NSP targets relating to key populations.

Respondents recognised the quality of the NSP (2007–2011) and felt that the guiding principles, goals and objectives fairly represented evidence-informed responses to address the needs of key populations. However, many stakeholders felt that little progress had been made towards achieving the targets that pertained to key populations specifically.

Concerns were expressed about limited high-level support and funding for programmes focusing on key populations. Additionally, poorly performing monitoring and evaluation, and accountability mechanisms were believed to have contributed to the slow progress made towards reaching NSP targets. Of particular importance was:

- The lack of progress towards the decriminalisation of sex work and SW-focused services;
- The failure to develop and effectively implement national HIV prevention, treatment, care and support activities for MSM and SW;
- Ineffective monitoring and evaluation strategies to collect data around key populations; and
- Failure to address multiple structural and social barriers which limit access to services, specifically stigma and discrimination within health and other services, and addressing violence, particularly sexual and gender-based violence, as well as access to condoms and condom-compatible lubricants.

Findings of the NSP Mid-term Review:

The NSP mid-term review assessed progress towards reaching the stated goals and objectives, and evaluated documented progress versus targets. Below is a summary of the relevant key population objectives and the reported progress.

Objective 2.5: Increased roll-out of prevention programmes for higher risk populations, specifically in prisons, among MSM, lesbians and transgender people and for SW and their clients.

Targets were set for MSM and SW, but no data was available to show progress on the percentage reached with customised HIV prevention packages. The reviewers commented on the lack of recent research on and dedicated funding and political support for SW, and urgently recommended a national SW study. They also commented on the lack of reliable population estimates for MSM and evidence of national MSM programmes, and recommended additional programme activity for the MSM community.

Objective 2.8: Develop and integrate interventions for recreational drug use in young people.

No specific mention of progress towards drug use interventions were identified in the mid-term review.

Objective 4.3: Investigate extent of HIV risk from IDU and develop policy to minimise risk of HIV transmission through injecting drug use and unsafe sexual practices.

No specific mention of progress on research among IDU was identified in the mid-term review.

Objective 8.3: Strengthen the implementation of policies and services for marginalised communities affected by HIV and AIDS.

Reviewers noted the difficulties in measuring such developments and no mention of progress around MSM, transgender people, IDU, SW, prisoners and migrants specifically were identified.

Objective 16.3: Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalised groups.

The lack of specific targets made assessment of progress difficult for the reviewers to ascertain.

Data Documenting National HIV Response and Key Populations

Monitoring of South Africa’s progress towards achieving NSP targets have been recorded through the NSP Mid-term Review and towards the UN Declaration of Commitment to HIV/AIDS (UNGASS) through the 2010 Country Progress Report.
IV. Key Populations

The reviewers did recommend law reform around the decriminalisation of sex work, the incorporation of the client’s of SW into HIV programmes, the provision of skills to handle homophobia and discrimination, in addition to the need to address gaps in knowledge around ‘vulnerable’ populations and HIV in South Africa in order to develop appropriate evidence-informed responses.37


The South African Country Progress Report on the Declaration of Commitment on HIV/AIDS (UNGASS report) is a reflection of South Africa’s national HIV response as well as its capacity to monitor and report on national efforts. This reporting progress also serves to identify gaps in data collection and programming.

UNGASS indicators 8, 14, 18–21 and 23 pertain to key populations. South Africa’s reported data for key populations (2010) is provided in table 1. Of the UNAIDS identified ‘most at risk populations’, data is only provided for MSM and for indicators 8 (percentage of most at risk populations who received an HIV test in the last 12 months and know their result) and 23 (percentage of most at risk populations who are HIV infected). Data is based on findings from the South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (2008). (SANAC, 2011a)

Less than a third of MSM interviewed had received an HIV test in the last 12 months and knew their status (27.2%) and an HIV prevalence of 13.9% among MSM was reported.

No data was provided on IDU or SW for any of the indicators. The 2010 South Africa Country Progress Report identifies measurement and reporting gaps for IDU and SW, and indirectly on coordinated programming for SW and IDU.

The data on MSM was obtained through population-wide surveys and may reflect underestimates of self-identified MSM behaviour.40
Table 1: South Africa 2010 UNGASS indicators for key populations

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Data Results 2008</th>
<th>Data Results 2009</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td>8</td>
<td>Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results</td>
<td></td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• African females aged 20–34</td>
<td>35.7%</td>
<td>48%</td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td></td>
<td>• African males aged 25–49</td>
<td>25.0%</td>
<td>52%</td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td></td>
<td>• Males aged 50–55</td>
<td>18.0%</td>
<td>3%</td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td></td>
<td>• Men who have sex with men</td>
<td>27.2%</td>
<td></td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td></td>
<td>• High-risk drinkers</td>
<td>23.1%</td>
<td></td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td></td>
<td>• Recreational drug users</td>
<td>22.5%</td>
<td></td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td></td>
<td>• People with disabilities</td>
<td>19.8%</td>
<td></td>
<td>National Communication Survey 2009.</td>
</tr>
<tr>
<td>9</td>
<td>Percentage of most at risk populations with HIV prevention programmes</td>
<td>Data not collected</td>
<td>Data not collected</td>
<td>Special survey</td>
</tr>
<tr>
<td>14</td>
<td>Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td></td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• African females aged 20–34</td>
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<td></td>
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<td></td>
<td>• High-risk drinkers</td>
<td>30.6%</td>
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<tr>
<td></td>
<td>• Recreational drug users</td>
<td>35.5%</td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• People with disabilities</td>
<td>21%</td>
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<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td>18</td>
<td>Percentage of female and male sex workers reporting the use of a condom with their most recent client</td>
<td>Data not collected</td>
<td>Data not collected</td>
<td>Special survey</td>
</tr>
<tr>
<td>19</td>
<td>Percentage of men reporting the use of condom the last time they had sex with a male partner</td>
<td>Data not collected</td>
<td>Data not collected</td>
<td>Special survey</td>
</tr>
<tr>
<td>20</td>
<td>Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected</td>
<td>Data not collected</td>
<td>Data not collected</td>
<td>Special survey</td>
</tr>
<tr>
<td>21</td>
<td>Percentage of injecting drug users reporting the use of a condom during last sexual intercourse</td>
<td>Data not collected</td>
<td>Data not collected</td>
<td>Special survey</td>
</tr>
<tr>
<td></td>
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<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
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<tr>
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<th>Data Results 2009</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td>23</td>
<td>Percentage of most at risk populations who are HIV infected:</td>
<td></td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• African females aged 20–34</td>
<td>32.7%</td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
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<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
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<td>6.0%</td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• Men who have sex with men</td>
<td>9.9%</td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• High-risk drinkers</td>
<td>13.9%</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Recreational drug users</td>
<td>10.8%</td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
<tr>
<td></td>
<td>• People with disabilities</td>
<td>14.1%</td>
<td></td>
<td>South African national HIV prevalence, incidence, behaviour and communication survey 2008</td>
</tr>
</tbody>
</table>
V. Men Who Have Sex with Men (MSM)

MSM are part of every community around the world and from countries with medium-to-high HIV prevalence have been shown to be nine times more likely to test HIV-positive compared to men in the general populations. Studies have indicated that epidemics of HIV among MSM in low- and middle-income countries appear to be partly driven by discrimination and human rights abuses, cultural and religious influences and a lack of appropriate prevention strategies, with little recognition by policy makers of the needs of MSM, resulting in poor programming for these communities. Global estimates for HIV prevalence among MSM is around 6% and prevention services appear to only reach about one in ten MSM. Less than one-third of MSM participating in a large international online survey reported to have tested for HIV in the previous year and knew their status. Data from Africa is limited to small cross-sectional studies, but data from all parts of Africa have identified populations of MSM and HIV prevalence ranging from 6–37%. The epidemiological data and evidence of poor access to HIV services informs the need to address structural and social barriers that perpetuate vulnerability to HIV and informs the need for roll-out of evidence-informed interventions, particularly in Africa.

Unprotected receptive anal intercourse (URAI) is the key risk factor for HIV transmission among MSM and carries a higher risk of HIV transmission than other forms of sexual practices.

In South Africa, MSM communities not only experience high HIV prevalence but also multiple barriers to accessing HIV prevention and treatment services. There are established ‘gay’ venues and areas in most major urban areas. Research conducted in more rural areas of the North West, Mpumalanga and the Eastern Cape provinces have identified the presence of MSM and the need for health services. Among the 1 738 men from the Eastern Cape and KwaZulu-Natal who participated in a recent household survey, 5.4% (95% CI 4.4–6.6%) reported some form of consensual same-sex behaviour. Accessing and obtaining accurate information about non-gay identified MSM is a challenge which needs to be overcome in order for the risks of unprotected anal intercourse between men to be appropriately addressed.

South Africa’s constitution does uniquely provide significant protection against discrimination based on sexual orientation in addition to legislation that allows for jurisprudence and same-sex marriage. However, despite these legal protections and cultural advances, MSM still face challenges in accessing appropriate health care services, which are limited in scope and mostly provided by NGOs funded through external sources.

Case study

“Nurses laugh when gays go in the clinic. Nurses they embarrass gays. Go in the clinic ask me why you sore. Nurse see[m] me not walking straight, my legs apart. They say it’s because of these things we doing. That’s why I’m feeling pain. Nurses don’t know but they tell me. They scream shout. I wait till 2pm no folder not seeing the doctor. I was angry I go home, I left clinic. Nurse rude like to embarrass gays, they laugh talk nonsense. Here in clinic we don’t get respect. I don’t think nurses got training. It’s not easy for gay. I don’t go to clinic

* Non-gay identifying MSM include men who have sex with other men but do not identify as gay. This group could include bisexual and heterosexual MSM.
here, go to a private doctor in town. Nurses very to gays, rude to us. I want to beat them sometimes because I got angry. My temper lose it easily. No more to clinic, no more.” *

HIV Epidemiology of MSM in South Africa

HIV prevalence among adult MSM from major urban centres has been shown to range between 10 and 50%. The table below provides a summary of HIV prevalence data for MSM to date. HIV prevalence among MSM has been estimated to be more than twice that of adult males in the general population. (Rispel and C. A. Metcalf, 2009) Modelling data has estimated that 7.9% of all new HIV infections occur among MSM and 9.2% of all new infections are due to MSM and their partners, highlighting that national HIV prevention interventions have not been effective in preventing HIV infections among MSM.37

Table 2: HIV prevalence data for MSM (2005–2010)

<table>
<thead>
<tr>
<th>Study location</th>
<th>Date</th>
<th>HIV prevalence 95% CI</th>
<th>Sample size</th>
<th>Methodology/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Eastern Cape</td>
<td>2006</td>
<td>11.5% (2.4–30.2%)</td>
<td>47 MSM out of 1277 men</td>
<td>Cross-sectional analysis of baseline interview, part of cluster randomisation trial among men 56</td>
</tr>
<tr>
<td>Soweto</td>
<td>2008</td>
<td>13.2% (12.4–13.9%)</td>
<td>378</td>
<td>Respondent driven sampling 60</td>
</tr>
<tr>
<td>Johannesburg and Durban</td>
<td>2008</td>
<td>43.6% (37.6–49.6%)</td>
<td>266</td>
<td>Respondent driven sampling 61</td>
</tr>
<tr>
<td>Gauteng, Western Cape and KwaZulu-Natal</td>
<td>2008</td>
<td>14.1%</td>
<td>692</td>
<td>Self report, cross-sectional survey 62</td>
</tr>
<tr>
<td>Cape Town, Durban and Pretoria</td>
<td>2008</td>
<td>35%</td>
<td>74</td>
<td>Opportunity sampling and snowballing in study among drug users. Sub-sample of 34 MSM 63</td>
</tr>
<tr>
<td>Cape Town</td>
<td>2009</td>
<td>10.4%</td>
<td>539</td>
<td>Venue-based sampling 64</td>
</tr>
<tr>
<td>Eastern Cape and KwaZulu-Natal</td>
<td>2010</td>
<td>20–50%</td>
<td>1738 households, 5.4% reported consensual MSM behaviour</td>
<td>71% provided blood samples – prevalence ranges dependent on type of MSM behaviour reported 57</td>
</tr>
</tbody>
</table>

Risk Factors for HIV among MSM in South Africa

Structural factors

Laws and policies exist in South Africa to protect MSM from discrimination. The Constitution of the Republic of South Africa (1996), specifically prohibits unfair discrimination on the grounds of sexual orientation under Section 9. (South African Government, 1996) Litigation brought to the Constitutional Court challenging discriminatory laws and policies on the basis of equality resulted in the supportive legislation which exists today. Important cases leading to current legislation include:

- The National Coalition for Gay and Lesbian Equality versus the Minister of Justice ‘19991, which resulted in the overturning of the common law crime of sodomy;
- The National Coalition for Gay and Lesbian Equality versus Minister of Home Affairs 20002

* MSM community member, story related by Martha Qumba
SA 1, which gave immigration rights to same-sex partners:

- Satchwell versus President of the Republic of South Africa 2001 \(^6\). SA 1 gave access to employee benefits for same-sex partners; and

- Constitutional Court ruling in December 2005 following the case of Fourie and the Lesbian and Gay Equality Project on the discriminatory nature of the then Marriage Act, leading to the approval of the Civil Union Act in 2006.


The legal framework needs to be supported by additional policy to extend the rights of sexual minorities into other government departments, including Education, Justice and Social Development.

Importantly, mainstream public sector health services fail to address the health needs of MSM. \(^6\). Coverage of existing services is limited to major metropolitan areas and no national government supported programme exists. \(^6\)

In addition to health services, criminal justice services are required to address several similar barriers in order to facilitate access to services. Particularly, there have been concerns that the prevalence of sexual violence affecting men is under-reported due to insensitive justice services. \(^6\)

Within the prison system sexual coercion and violence between men has been documented and it is believed to be under-reported and is an additional risk factor for HIV infection among detainees. The lack of integrated referral systems also compromises the degree of holistic care provided. \(^6\)

**Societal factors**

Key social and societal factors, which influence vulnerability to HIV and access to HIV prevention, treatment, support and care services include inequality, violence, racism, gender norms and cultural expectations, stigma, homophobia and discrimination. \(^22, 65, 70–77\)

The pervasive nature of crime in South African society, in particular the prevalence of sexual violence, is a risk factor for HIV infection. Homophobic violence has been shown to affect South African MSM and contribute to ill health; 16% of MSM participating in a recent study by Nel et al., reported some form of physical abuse. Sexual violence has been reported to range from 6–22% among MSM. The levels of male sexual violence are likely to be an underestimation due to perceived insensitivity of police services. \(^68, 78\)

Heteronormativity, cultural and religious beliefs influence levels of external and internalised homophobia and discrimination as well as the ability of MSM to engage with health workers around sexual behaviour and to access services. \(^67, 75, 79–81\)

Social vulnerability and racial discrimination are further social influences which are negatively associated with HIV testing practices and the accessibility and effectiveness of HIV prevention interventions. \(^65, 67, 71, 76, 82\)

Restricted availability and access to HIV prevention and treatment services and poor education are additional social factors which increase vulnerability to HIV among MSM. \(^65, 64, 83\)

**Individual risk factors**

In South Africa high risk-taking behaviours, limited knowledge about HIV, high levels of alcohol use and human rights abuses have been identified as individual risk factors for HIV infection among MSM. \(^55, 60, 61, 64, 76, 81, 82\)

Several small cross-sectional surveys and other forms of research have identified high-risk sexual behaviours among MSM including the practice of unprotected anal intercourse, multiple and concurrent partners, and sex work. \(^55, 60, 61, 64, 81, 84, 85, 86, 87\)

A recent cross-sectional survey conducted in Gauteng, Cape Town and KwaZulu-Natal identified higher levels of HIV testing practices among older men and MSM identifying as gay. Geographic variability in HIV testing practices among MSM was also shown, with participants from KwaZulu-Natal being less likely to have had an HIV test compared to participants from Gauteng and Cape Town. \(^50\)

High levels of internalised stigma as a result of sexual orientation and behaviours have been
identified among MSM. This stigma may be compounded in the presence of HIV, in itself associated with an increased likelihood of social isolation, loss of housing and employment.\textsuperscript{76,78,88}

In addition to high levels of alcohol abuse documented among MSM across the country, high levels of methamphetamine use among MSM seeking health care in the Western Cape have been reported and heroin use among MSM has also been documented. Among drug-using MSM, substances were reported to be used as a means to facilitate sexual encounters and have been associated with unprotected anal intercourse.\textsuperscript{63,89,90,91}

Data limitations
No national MSM sample-size estimates exist and HIV prevalence findings may have limited generalisability. Generalised, non-targeted studies are unlikely to provide true estimates due to the complex social influences on reporting same-sex behaviour, particularly for non-gay identified MSM. Data gaps also exist in relation to effective combination prevention interventions and around implementation science.

MSM Programming

Demand for MSM programming
Preliminary data supports high HIV prevalence among MSM yet limited data exists on the size of the MSM population and the need for health services in areas beyond major urban areas. MSM services are provided in several locations and where existing the services are being utilised, and it appears that the uptake is increasing.\textsuperscript{6,59} The needs of non-gay identified MSM are even less well understood, yet as the major route of HIV transmission among MSM is through unprotected anal intercourse, and since anal intercourse has been shown to be a common practice among heterosexual South Africans, all health services should incorporate strategies to address anal sex. Through the provision of non-discriminatory services it would be easier for clients to discuss sexual practices, allowing for appropriate risk-reduction plans to be made.\textsuperscript{37}

Access to services
Mainstream public sector health services fail to address the health needs of MSM and have been shown by recent research to be a barrier to accessing care, and the coverage of existing services is limited and no roll-out or integrated referral system exists for the MSM targeted programmes.

Many barriers to accessing services are also factors which influence the vulnerability of MSM to HIV. Pervasive prejudice and stigma have been highlighted as playing an important role in limiting access to care. The lack of MSM-related training and awareness of sexual practices and risks among service providers may not facilitate access to care. Limited awareness around existing services which cater for MSM limits the coverage and impact of these services. Fear of testing for HIV and the related stigma of testing HIV-positive exist and limit HIV testing services in their ability to facilitate clients into the health services, which include prevention, treatment, care and support services. Non-gay identified MSM face additional barriers to accessing services. Gay targeted health promotion messaging and programming provided by gay media and LGBTI organisations may not reach these men.\textsuperscript{6,22,51,61,92}

Much of the MSM population is affected by poverty and requires access to sensitive public services. This may be in contrast to the misconception among some service providers that most MSM are affluent and able to access private health care services.\textsuperscript{59}

Scope of programming
On a limited level there is some programming which is provided in certain provinces, with support from provincial health departments, but current coverage is severely limited in terms of numbers of MSM reached and geographic availability.

No national Behaviour Change Communication (BCC) campaigns for MSM have been launched. Soul City has recently been approached by the SANAC LGBTI sector and expressed interest in developing a plan for this to happen. There is currently no MSM-related messaging included in the existing HIV communication strategies aimed at the general population or young people specifically.

General messaging around risks of unprotected anal sex in HIV transmission for sexually active people is not widely disseminated. Elicitation of anal sexual practices is also not included in standard HCT procedures for all.
MSM targeted services are lacking in most areas of the country. Those that do exist are based in major cities and are provided by civil society organisations, some of which obtain support from provincial government. Many organisations are involved in advocacy and information dissemination efforts and many also provide HCT services. However, there are very few which provide HIV prevention, treatment, care and support services for MSM. The role of civil society in providing targeted services may be the best model, with support and linkage with government services, should this form part of an overall health and justice service which is sensitive to the needs of key populations, which include MSM. Focus needs to be placed on ensuring that organisations which provide MSM specific services are located in at least one major urban area per province. The role of outreach and use of mobile and support services to broader regions may be a feasible way to increase coverage.

**MSM funding**

No national funds are provided to support MSM activities but the Western Cape and the North West provincial Departments of Health have partnered with NGOs to provide several services targeting MSM.

International governmental donors providing support for MSM programming include PEPFAR via the US Agency for International Development (USAID) and the Centre for Disease Control and Prevention (CDC), Dutch, Swedish and Australian governments have also supported MSM work. Atlantic Philanthropies, OXFAM, The Schöler Foundation, Ford Foundation, the Open Society Institute of Southern Africa (OSISA) and the Open Society Foundation of South Africa have supported MSM work. Research activities have been supported by The American Foundation for AIDS Research, the United States National Institutes of Health, the Development Centre for AIDS Research, the Ford Foundation, the International AIDS Vaccine Initiative (IAVI), the Population Council, OSISA and Johns Hopkins University. UN structures, particularly UNDP have supported MSM-related research, advocacy and other activities to date.

**SWOC Analysis for MSM in South Africa**

**Strengths**

**Data**

- Data exists on high HIV prevalence and risk behaviours of MSM to inform evidence-based programming
- Additional MSM prevalence studies are planned or underway

**Advocacy**

- Establishment of the SANAC LGBTI sector in 2011, with LGBTI representation on several SANAC sectors and technical task teams
- Support from several provincial Departments of Health and the national Department of Justice to improving access to services for MSM

**Resources**

- Network of partners with history of supporting MSM targeted activities exist
- Calls for proposals for larger scale interventions targeting MSM and other key populations are currently underway
- Technical and financial support of international development, research and support agencies exist (UNAIDS, UNFPA, OSISA, UNDP, CDC, USAID, amFAR and the Humanist Institute for Development Cooperation [HIVOS])

**Programming**

- Established SANAC LGBTI sector with programming emphasis on MSM
- LGBTI NGOs are able to access MSM who are reluctant to use mainstream health services for sexual-health related problems (including HIV) because of homophobic, stigmatising attitudes among many service providers
- Existence of MSM expertise exists in the country

**Monitoring and Evaluation**

- Increase level of current participation by MSM NGOs in the country reporting procedures,
for example mid-term reviews, UNGASS and National Composite Policy Index

**Weaknesses**

**Data**
- Further and more accurate data required for continuing evidence-based programming
- Limited knowledge of MSM sub-groups
- Lack of data on economic evaluation of MSM interventions
- Sample-size estimations needed
- Lack of data on sex work among MSM
- Operational research required
- Detailed understanding of MSM behaviours lacking

**Advocacy**
- Limited high-level support for MSM issues from government structures
- Despite the establishment of the SANAC LGBTI sector, representation on other national and provincial structures is limited

**Resources**
- Lack of sustainable funding and funding from national and provincial government

**Programming**
- Failure to target non-gay identified MSM with messaging and services
- Lack of MSM-inclusive BCC campaigns to provide prevention messaging and to counteract misperceptions and myths regarding risk behaviours such as anal sex
- Limited coverage and lack of national programming
- Programming based on notions of abstinence, partner reduction and condom use do not adequately address specific dynamics and social contexts facing MSM in South Africa, and there is a need for the inclusion of other components of HIV programming, including biomedical prevention interventions (PEP and PrEP), programmes aimed at building social capital and addressing socio-economic disparities
- Barrier methods are not freely available and accessible, particularly condoms (male and female) with water-based lubrication
- HIV prevention packages inclusive of peer education, condoms and lubrication. HIV testing, positive prevention, PEP, STI diagnosis and treatment are limited
- Minimal MSM messaging in the general media and within national HIV messaging campaigns
- Effective HIV counselling to include emphasis on discordant couples and substance abuse
- Treatment – increase access to sensitive, appropriate treatment, care and support
- Improved access to justice services required

**Monitoring and Evaluation**
- Limited coordination of reporting and programme evaluation

**Training**
- Health worker training around MSM sensitisation and MSM service is limited to that provided by NGOs in only a few metropolitan areas

**Funding**
- Sustainable funding and support from the national government is a current gap

**Opportunities**

**Data**
- An HSRC/CDC Marang study will provide baseline regional data on HIV prevalence and risk behaviours, national HIV prevalence estimates, establish a protocol for an implementable national HIV behavioural surveillance programme for MSM, and provide country level data for UNGASS indicators for MSM.
- Recent findings of the iPrEx trial may pave the way for future biomedical prevention trials among MSM in Africa, including rectal microbiocide trials
Advocacy
- Establishment of the SANAC LGBTI sector and representation on SANAC structures will increase representation of MSM in relevant forums

Resources
- International funders, including The Global Fund are supporting targeted interventions
- A portion of the South Africa Round 10 Global Fund has been allocated to MSM

Programming
- Effective small-scale programmes have been implemented in major cities which can be scaled up to increase coverage and access to services

Monitoring and Evaluation
- Emphasis is being placed on a national level to improve the SANAC monitoring and evaluation system

Challenges

Data
- Data from sample estimations may not accurately reflect population sizes and policy and decision makers may opt to not support programming aimed at key populations

Advocacy
- Monitoring is required to ensure continued advances in MSM rights and awareness
- Representation and engagement is a long-term investment

Resources
- Competing priorities
- Inefficient use of funding or mismanagement may jeopardise the benefits of increased MSM funding

Programming
- Evidence-informed programmes may be difficult to develop and may face several barriers to effective roll-out, such as high levels of stigma and discrimination
- Demand for services needs to be ensured and barriers to access may prevent impact resulting from programming

Monitoring and Evaluation
- Sidelined by mainstream servicing
- Complex requirements of reporting may divert resources away from service provision and too much time spent on administrative activities
Previously, in the context of HIV prevention, transgender women were considered as part of the larger MSM population. However, transgender people have specific and distinct needs, which include but are not limited to differing physical characteristics, unique health care needs, and the right to self-determination with respect to gender identity. As a result, transgender people need to be considered as a separate population group requiring unique considerations and prevention efforts.\(^2\)\(^3\)\(^4\)

The most comprehensive epidemiological studies among transgender people have been done in California and found HIV prevalence among transgender females to range between 8 and 68%. The same studies found HIV incidence to range between 3.4 and 7.8 per 100 person-years.\(^5\)\(^6\)

Increased vulnerability is associated with barriers to accessing health care and prevention services, poverty, discrimination, high rates of sex work as a result of economic need, abuse, rape and substance use.\(^2\)\(^3\)\(^7\)

Case study

"Upon meeting Jennifer, I was taken aback by how femininely she comes across. It is evident this 28 year old pays particular attention to fashion sense and grooming. Jennifer was born in January 1982 as a male child. Jennifer always knew she was different and remembers having a strong desire to wear dresses like the cousin she grew up with."

Though identifying with traits and habits from the opposite gender from a young age, Jennifer was reminded sternly by her family, friends and peers that she has to behave in line with what society determined to be ‘male behaviour’.

“I was often reminded in the harshest way that I was still a boy and had to behave as such,” Jennifer says. “I was beat often, both at home and school, from a very young age”. This clearly did not put off this determined woman. She says that adversities became challenges on which she firmly stood her ground.

The biggest challenge for Jennifer was being born and raised in a small town in the Eastern Cape. “Growing up in the rural Eastern Cape presented unique challenges in that there was no information regarding my situation. Up to the age of fifteen, I did not even know what this phenomenon was called. The only thing that was very clear to me was the desire to become a woman.”

Her situation was very controversial both at school and at home. Jennifer assigns this controversy to the fact that people did not understand her situation. Circumstances worsened for Jennifer in 1999 when her sister was murdered. She subsequently moved to Cape Town to live with her cousin.

While it was a culture shock having to adapt in the big city, it was good to have the opportunity to expand her knowledge of this condition in a city with people who seemed more knowledgeable. Her new school presented many new challenges and she found it difficult to fit in. The ‘gay crowd’ was not very accepting and ‘the normal’ kids did not understand her situation. As a result she ended up being pushed from one group to the other.”

More attention is being placed on the needs of transgender people, however, research, policy and programming is all needed to address issues of the body, health services, gender identity, behaviours and human rights issues as they pertain to transgender people specifically.\(^2\)

The Alteration of Sex Description and Sex Status Act No. 49 of 2003 allows for legal gender change. The need for gender-congruent identification is necessary to empower people to realise their

\(^*\) Jennifer’s story, written by Charl Marais, http://www.genderdynamix.co.za/content/blogcategory/69/205/5/5/ accessed on 02 August 2011
human and health rights and few individuals attempting to ensure documentation accurately reflects their gender identity, are able to do so.  

Classifying transgender populations as a sub-population fails to recognise the spectrum and differing sexual practices of transgender people. Classifying transgender women as MSM may falsely lead to the premise that these individuals have sex with men, and classifying transgender men as Women Who Have Sex with Women (WSW) may lead to the belief that these people have sex with women. Sexual and reproductive health issues particular to this group are often not addressed. Barriers preventing access to health services by transgender people need to be addressed. Specific health care issues include sexual health services (HIV and STI prevention, testing and care), cancer services (specifically for prostate, cervical and breast cancer) and drug therapy (hormone treatment and drug interactions), in addition to mental health and substance abuse services. Pervasive stigmatisation, denial and the hidden nature of some transgender people have led to the exclusion of transgender people from much research, and globally data for this population is lacking. Discrimination and rejection by family members and communities lead to many transgender people and transgender sex workers being homeless, facing poor employment prospects and having problems within the workplace.  

The human rights of transgender people and their right to freedom from discrimination, right to dignity and access to health care are enshrined in multiple local and international charters and these should be ensured.  

Programming  
Services for transgender populations are limited, however, Gender DynamiX provides support groups, legal assistance in regards to Act 49, and support in terms of medical treatment (hormones and surgeries etc.).

Planned Projects Addressing Needs/Gaps of Key Populations in SA for 2012–2015  
1. The second Transgender Health and Research Conference will be organised by Gender DynamiX in November 2011. This conference will also look at sexual and reproductive health of transgender people and discuss HIV in depth.

2. Research concerning sexual and reproductive health and transgender people in SA will be conducted by Gender DynamiX in 2011 (results are expected to be available early 2012), focusing on specific transgender issues, including vulnerability to HIV.  
3. Gender DynamiX will be starting a structural HIV programme in which peer-to-peer educators will be recruited in all South African provinces. Furthermore, it will include a component focusing on the sensitisation of existing VCT and treatment services. This was scheduled to start in May 2011.

Funding  
Funding is received from The Atlantic Philanthropies, Astraea Lesbian Foundation for Justice, Gender Odyssey Database, University of Washington, Multi-Agency Grants Initiative (MAGI), HIVOS, Breadline Africa, the Wheat Trust and the American Foundation for AIDS Research, among others.

SWOC Analysis for Transgender People in South Africa  
Strengths  
- South African law allows for legal change of gender without the need for reassignment surgery  
- Established NGO which focuses around issues of transgender people  
- A network of partners providing support for transgender people  

Weaknesses  
- Lack of data around HIV among transgender people in South Africa  
- Research mentioning transgender people is not clear as to whether it deals with transgender women or transgender men, and what the specific issues are that they face  
- The specific needs of transgender people are not covered in existing VCT and treatment services  
- Services catering to MSM or men in general are not accessible to transgender people
Opportunities
- The transgender position paper provides guidance on important issues for consideration by policy and programme developers.
- A network of LGBTI and trans-organisations exist, which can be used to further advocate around the health needs and information gaps pertaining to transgender people.

Challenges
- Service providers need to respect the gender identification of transgender people.
- Overcoming social and structural barriers preventing access to HIV services.
- Addressing social issues which compound vulnerability, including unemployment, poor education and poverty.
VII. Injecting Drug Users (IDU)

In 2007 it was estimated that globally there were between 11 and 21.2 million individuals who injected drugs. The rapid escalation of HIV prevalence among populations of IDU has been typical in many countries with an estimated 3 million (range 0.8–6.6 million) HIV-infected IDU globally. The recent ‘war on drugs’ has not been effective in controlling drug use. There has been a 35% increase in global opioid consumption between 1998 and 2008 despite increased expenditure on repressive measures aimed at reducing drug supply and consumption.

Drug trafficking and weak border controls are believed to be affecting the spread of drug use in Africa. Many drugs enter South Africa from Asia and South America with most heroin entering from Mozambique. It is estimated that there are between 10 000 and 50 000 IDU in South Africa, which is approximately 0.15% of the adult population. However, these estimates are based on limited data and may not accurately reflect drug use practices in South Africa.

The most commonly injected drugs in Africa are heroin, cocaine and speedball (a heroin and cocaine combination). The number of heroin users and IDU in Africa is increasing, with 0.2% of African adults estimated to be heroin users, which is in line with the global average. As a substance of abuse leading to inpatient treatment, heroin use appears to be less prevalent than alcohol and cannabis use. There are, however, indications that the prevalence of heroin use is increasing. Of the 2 660 admissions to Cape Town’s drug treatment centres in the first half of 2006, 14% were associated with heroin use. The proportion of admissions related to heroin use as the primary substance of abuse increased from 2% in the first half of 1998 to 14% in 2006. Similar increasing trends in heroin-related admissions have also been reported in Gauteng.

OST has been shown to be the most effective treatment for opioid dependence. IDU who remain in medically assisted treatment are six times less likely to become HIV infected. NSE programmes have shown to decrease needle reuse and frequency of injections by 60%. The increased availability of sterile equipment and decreased amount of

and the enforcement of policies pertaining to the registration of treatment centres affects the ability to ensure high quality, effective treatment of heroin abuse in South Africa.

Most heroin is smoked, either alone or in combination with other drugs, and primary use has been reported among 9–26% of South African heroin users.

The ease via which HIV can enter the body when injecting drugs and the closed social networks of many IDU facilitates rapid spread.

Furthermore, the use of contaminated injection equipment is the major risk factor for HIV infection among IDU. The transmission of HIV through drug use is estimated to be six times higher than penile-vaginal sex.

The partners of IDU are also vulnerable to sexual transmission of HIV as a result of multiple factors including, but not limited to, the lack of awareness of partners’ injecting practices, poor knowledge about HIV risks associated with IDU, as well as low condom usage within marriages.

Injecting drug use is associated with medical and social harms such as HIV, viral hepatitis and other infectious diseases, as well as with mood, anxiety and psychotic disorders. Sex work and crime have also been associated with drug practices as a result of the need for income generation to support drug habits, and the use of drugs as a coping mechanism. Social isolation and marginalisation may also result from drug use.

OST has been shown to be the most effective treatment for opioid dependence. IDU who remain in medically assisted treatment are six times less likely to become HIV infected. NSE programmes have shown to decrease needle reuse and frequency of injections by 60%. The increased availability of sterile equipment and decreased amount of
contaminated needles also leads to reductions in risk of HIV infection. Barriers to medically assisted treatment include cost of treatment, legislation, restrictive inclusion criteria, limited governmental support, lack of confidentiality, stigma and discrimination aimed at people who use drugs.\textsuperscript{102, 109, 110, 111}

However, despite the evidence, globally only 82 countries or territories provide some form of NSE. In Africa it is estimated that less than one needle per year is distributed per person who injects drugs. OST coverage in Central Asia, Latin America and sub-Saharan Africa is estimated to be 1 out of every 100 people who injects drugs. In 2007 it was estimated that less than 3 U.S. cents was spent on harm reduction per day per person injecting drugs in low- and middle-income countries.\textsuperscript{10, 10, 112, 113}

Based on the social and public health costs associated with withholding ART and other services from IDU, the WHO, UNODC and other international development partners recommend the inclusion of OST, NSE and ART programmes as part of holistic IDU risk-reduction programmes.\textsuperscript{*} Novel strategies to regulate drugs, undermine organised crime and safeguard the health of citizens are needed in light of current failures to address increasing drug consumption trends, and maximise human health, safety and development.\textsuperscript{10, 106, 110, 112, 114–118, 119}

Punitive laws exist around the possession, selling and use of drugs, including heroin, with the focus of government interventions placed around control measures.\textsuperscript{110} National health policy documents are supportive of harm reduction programmes but do not specify the inclusion of OST and NSE as part of harm reduction strategies.\textsuperscript{10, 116, 120, 121}

Case study

“I underwent a tremendous number of interventions. I think for me, the way that I make sense of it, is that it was a kind of cumulative effect of all the treatment. I was quite... confused. Eventually I got to a point where I was willing to do what I needed to do at that point all the interventions that I’d experienced had some meaning. Then I cleaned up in a halfway house and after having had multiple entries, just stayed there and I’ve been clean ever since then.

It’s very, very hard to stay clean. Initially, I mean, I think for the first nine months that I was clean it was the first thing I thought every morning as I woke up – was about heroin, and it was a daily decision. It’s not enough to just wake up in the morning and say ‘I’m not going to use’, you are presented with situations during the day where you have to continue making decisions and I think a lot of that was habit, but a lot of it was kind of was biochemical. I was just so used to being ‘stoned’ that everything reminded me of heroin, and I think that was really hard, part of that psychologically, part of that as I say I think is really physical. I needed an awful lot of support to do that. Fortunately it was available.

I think what the medication interventions had done was to keep me alive. My use was very, very, very chaotic, and very dangerous, and I think that methadone maintenance kept me alive. I think that detoxing periodically kept me alive. I couldn’t stop using heroin. I was too sick. I was too frightened of being sick. It was very very difficult for me just to stop using heroin, just to go ‘cold turkey’ and I never managed. I think if I hadn’t got medical help each time I’d detoxed, I wouldn’t be alive today.

I think there is a difference in treating long-term heroin addiction. What I think is that early intervention in heroin addiction, within two/three years are much more likely to succeed. I think after five years of being addicted to heroin for five years, there’s a very very low recovery rate. I think that, early high-level interventions are important. I think that one of the mistakes that I made was the intervention, my early interventions were all low-level interventions, I think that that contributed to the duration of my addiction.

Anywhere in Southern Africa where people are intravenously using they’re in a very high risk of contracting HIV and I think it’s a given that people will not share needles if they have to use. I think the more clean needles available the less likely they are to contract HIV through intravenous sharing. In the end if there’s a high incidence of intravenous heroin use, more of needle exchange programmes and methadone maintenance programmes. I think there needs to be a comprehensive intervention, and not just to deal with the medical. So I think for the individual,
medically, psychologically and spiritually they need to be supported and nurtured. The other thing that I believe is that unless there are resources available, brief interventions are going to be of limited value. I think brief intervention where in that suggestions are made about long-term care."* 

HIV Epidemiology among IDU in South Africa

There is an evident gap in accurate data around HIV prevalence among people who use drugs, particularly among IDU, in South Africa. IDU are at elevated risk for HIV infection through the practice of needle sharing and use of unclean equipment. 106, 122–124 Several small studies in major cities have highlighted high HIV prevalence among IDU.

Cross-sectional surveys among drug users, including IDU, have identified HIV prevalence to range between 5.4 and 35% among different groups of drug users in different cities in South Africa. Data to date may not be a true reflection of HIV prevalence among drug users, including IDU as most have used opportunity sampling methods and a significant number of participants have declined to be tested. Table 2 provides a summary of HIV prevalence data among drug users, including IDU to date.

There is great scope for improvement of HIV services provided to IDU.10, 106, 116, 117 Only 4–34% of patients admitted for substance abuse treatment reported having had an HIV test in the previous 12 months.104

Risk Factors for HIV among IDU

Structural factors

Legislative Factors

The Medicines and Related Substances Control Act, the Drugs and Drug Trafficking Act and The Prevention of and Treatment for Substance Abuse Acts are all key aspects of legislation designed to control illicit drugs in South Africa.

The Medicines and Related Substances Control Act (101/1965) is structured around UN conventions on drug control. The Act provides the framework for drug control policy in South Africa.

The South African Drugs and Drug Trafficking Act (140/1992) outlines the punitive measures which the state will take in relation to drug manufacture, trafficking, selling and purchase of drugs. The maximum sentence for dealing in drugs is 15 years imprisonment.

Table 3: Summary of HIV prevalence among drug users, including IDU in South Africa (2000–2009)

<table>
<thead>
<tr>
<th>Study location</th>
<th>Date</th>
<th>Population</th>
<th>HIV prevalence</th>
<th>Sample size</th>
<th>Methodology/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Town, Johannesburg and Durban</td>
<td>2001</td>
<td>Street sex workers</td>
<td>27%</td>
<td>249</td>
<td>Data only presented for those who were accurately linked with HIV test results.125</td>
</tr>
<tr>
<td>Cape Metropole</td>
<td>2004</td>
<td>Heroin users</td>
<td>3%</td>
<td>239</td>
<td>Self-reported HIV status of those who had been tested.83</td>
</tr>
<tr>
<td>Durban</td>
<td>2008</td>
<td>Drug-using SW</td>
<td>35%</td>
<td>23</td>
<td>37% (19/52) of participants reported IDU practices. 23 of 28 drug-using-SW who acted as key informants accepted testing. HIV data by IDU practice not provided.106</td>
</tr>
<tr>
<td>Cape Town, Pretoria and Durban</td>
<td>2009</td>
<td>IDU</td>
<td>20%</td>
<td>55</td>
<td>Snow-ball sampling – only 35 participating IDU agreed to HIV testing127</td>
</tr>
</tbody>
</table>

* "Treating Heroin Addiction" – the experience of a recovered IDU. Story documented by Monika dos Santos.
The Prevention of and Treatment for Substance Abuse Act (70/2008) outlines the state’s responsibility to use harm reduction to combat substance abuse. It describes harm reduction as including ‘holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance abuse.’ There is no explicit mention of the need for inclusion of NSE programmes and OST.

Current laws force IDU ‘underground’ and limit their ability to access health services, and the limitations on OST and NSE programmes limit treatment options available, and hence may be associated with increased duration of drug-using patterns and risk for HIV infection.\(^\text{121, 128, 129}\)

Programmes providing needle exchange and substitution therapy have been shown to be effective in preventing new HIV infections and are gateways to HIV testing and other health services. The role of NSE and OST and links between drug use and HIV are not specifically included in South African legislation.\(^\text{120, 121}\)

### Social factors

Substance use is an acceptable part of South African culture and is commonly practised. Alcohol and cannabis are widely used across South Africa. However, the societal acceptability of different substance use practices contribute to the perception that certain substances are more acceptable than others. Injecting drug use is surrounded with the most stigma. IDU often face discrimination at the hands of family members, health providers and law enforcement agencies. Such discrimination and stigma have been reported as barriers to accessing HIV testing services and other medical services in South Africa.\(^\text{130–133}\)

Several socio-economic factors including unemployment, poor living conditions and poor education increase vulnerability to drug use and decrease adherence to drug treatment programmes.\(^\text{126, 128, 129}\)

Drugs often have influential roles within several communities, including prison populations and gangs. Links between buying, selling and using drugs and sex work have been identified among SW. The services SW provide to clients of all races result in potential cross-cutting links between SW, drugs and HIV infection.\(^\text{126, 131, 132, 134, 135}\)

### Individual risk factors

- Unsafe sex practices under the influence of substances\(^\text{89, 127, 131–133, 136}\)
- Lack of knowledge about risks related to unhygienic injecting practices\(^\text{103, 106, 129, 130}\)
- Experimenting, peer pressure or the need to flee from reality as reasons for using drugs\(^\text{129, 135}\)

### Limitations

A limited number of studies have been conducted, most of which have been explorative qualitative studies, providing depth of information but limited representation and generality. No accurate countrywide epidemiological data is available, including sample-size estimations. The lack of surveillance data hinders the ability to assess the impact of drug trafficking and it’s use, and it’s relation to HIV transmission and prevalence in Africa, as well as the ability to observe trends in drug practices over time.

### IDU Programming

#### Scope of programming

A range of prevention, treatment and support programmes are implemented in an attempt to control and stop drug use among individuals in South Africa. Limited services targeting IDU exist, and are concentrated in major metropolitan areas, with most services provided by the private sector.

1) **HIV-prevention Services**

Currently there are no specific HIV and drug prevention interventions which focus on IDU specifically. In the current framework, programmes which are focused on addressing drug use more broadly aim to include aspects of prevention which are particular to IDU. The lack of UNGASS and NSP (2007–2011) reporting on IDU related activities suggests lack of monitoring and may suggest failure to meet IDU related service delivery and reporting commitments.\(^\text{3, 40}\)

2) **Drug Treatment**

Due to limited monitoring and local guidelines for the treatment of opioid dependence, the quality of treatment provided varies.\(^\text{136}\) Inpatient treatment for drug addiction, including heroin, is undertaken by several hospitals in major urban areas, with private
VII. Injecting drug users (IDU)

substance abuse clinics serving a proportion of drug users, including IDU who have the capacity to pay for treatment services. Heroin addiction is particularly challenging to manage and South African guidelines for the treatment of heroin/opioid dependence do not exist. Currently South Africa is the only country in Africa that provides OST. Most programmes are available through the private sector, at great cost.

The opioid substitution programmes that do exist are mostly provided through private care, however, access to safe injecting equipment is extremely limited. Within the public health system, methadone is available to hospitals but, in general, is reserved for the treatment of heroin intoxication and withdrawal. A long-term outpatient methadone maintenance programme has been operating from the Steve Biko Academic Hospital (formerly known as the Pretoria Academic Hospital) for several years.

3) Other Drug Prevention Programmes

In the Western Cape, the provincial government directs interventions which are aimed at four levels, namely at awareness and prevention, screening, assessment and brief intervention, and treatment and aftercare. The Department of Social Development has 16 district offices that coordinate services provided by local NGOs and the Department of Education runs specialised learner support services in eight education districts. Health worker training is provided by some provincial departments and ongoing service delivery and training of staff who work in this field is provided.

The Department of Social Development has implemented several demand reduction activities focusing on at-risk women and youth. The Department of Safety and Security and the Central Drug Authority (CDA) piloted a drug use prevention empowerment project – ‘Ke Moja – No thanks, I’m fine!’ – a drug awareness campaign inclusive of classroom-based leisure, life-skill and sexuality education components.

Demand and access

Currently there are no accurate estimates of the population of drug users and, as a result of legislation relating to drug practices, there is no clear outline of the demand for services targeting this group. Data presented earlier highlights that the proportion of heroin users admitted for inpatient drug treatment is increasing. A recent study by the Trimbos Institute has highlighted the apparent increase of practices among black Africans in Gauteng and in areas of Cape Town where previously drug use was not known to occur. A Technical Working Group (TWG) on IDU exists through UNODC which includes representatives from civil society, academic institutions, development partners and government.

Organisations providing programming for IDU

Currently, services for drug-using populations in South Africa are provided by government and civil society organisations. The departments of Social Development, Education and Health are actively involved in the provision of prevention, treatment and support services to drug users. The Department of Social Development is responsible for prevention programmes, while treatment falls under the guidance of the Department of Health and Provincial Departments of Education are tasked with the inclusion of drug prevention activities within their curricula and school-based health promotion programmes.

Several NGOs provide drug prevention, treatment and support services. The South African Council on Alcohol and Drug Abuse (SANCA) provides limited inpatient and outpatient support to drug users in need of treatment. Soul City also delivers communication programmes on alcohol abuse and other drugs, and Lifeline has drug counselling support services aimed at assisting drug users. Recently a pilot NSE programme for MSM who are IDU has been started by Health 4 Men in Cape Town, and a similar programme is planned for piloting in Gauteng.

IDU funding

The national government has allocated budgets to several departments to allow for financing of substance abuse interventions. However, this funding does not specifically target IDU and HIV prevention. Provincial governmental departments are responsible for allocating budget. One of the best multi-department approaches to substance use has been implemented in the Western Cape, where the Department of Social Development allocated approximately R52 million to substance abuse
prevention, treatment and support in 2009/2010. Of this, R25.5 million went towards inpatient treatment for substance use, covering treatment for almost 2000 adults and youth in state centres and not-for-profit organisations, and provided training to 54 professionals and 35 government officials. A sum of R10.8 million was provided for outpatient services and allows access to just under 3000 adults and youth, and training for 80 professionals. Additional funds were provided for other supportive services and training interventions. The Western Cape Department of Health allocated R6 million (2009/2010), approximately half of which was for opioid detoxification. The involvement of the Provincial Department of Education, Agriculture, Community Safety, Economic Development and Tourism also play a role within the multi-sectoral approach developed to address substance use and abuse in the province.

International support comes from the U.S. Government who, through PEPFAR, has supported research conducted by the MRC, and a small NSE programme in Cape Town. Additional support from international governments include The Netherlands, Luxembourg, Sweden and EU governments (list not exhaustive).

SWOC Analysis for IDU in South Africa

**Strengths**

**Data**
- Baseline prevalence data from some areas available
- Evidence available to support increased programming and funding allocations for HIV prevention programmes among IDU
- International evidence supporting effectiveness of harm reduction programmes
- WHO, UNODC and UNAIDS supports use of NSE and OST as part of harm reduction strategies.

**Policy**
- Harm reduction philosophy included in national policy
- Establishment of the IDU TWG

**Programming**
- Multi-sectoral approaches have been developed and implemented in the Western Cape and could form a model for replication in other provinces

**Funding**
- Assistance from development agencies to support this work

**Weaknesses**

**Data**
- Lack of population size estimates
- Limited samples included in prevalence studies
- UNGASS 2010 reporting did not include data on IDU
- An in-depth understanding of drug use behaviours of various drug-using populations and, accurate sample-size estimations do not exist, and, as a result, evidence-informed programmatic responses are limited
- Data on national prevalence of drug use, abuse and addiction does not exist, and is required in order to assess the scope of drug use and to serve as a baseline for the measurement of programmatic impact
- Monitoring and evaluation of drug prevention, treatment and support activities (and related indicators), well-defined Specific Measurable Achievable Realistic Time (SMART) output and outcome indicators are needed, together with feasible methods to verify the achievement of these indicators
- Research into the role IDU contribute to the spread of HIV and viral hepatitis through unsafe injection practices has not been completed
- Limited funding opportunities for collecting data on IDU exist

**Legislation**
- Criminalisation of drug possession
- The lack of government support for NSE programmes
VII. Injecting drug users (IDU)

Policy

- The current drug policy is inspired by the (unrealistic) wish to ban drug use and drug addiction and does not place enough emphasis on maximising the health of drug users
- There is a lack of strategic health care policies that address the co-morbid factors affecting drug users and IDU, such as HIV/AIDS and psychiatric illness
- A clear definition of drug and HIV prevention packages, based on a harm reduction philosophy, does not exist
- Collaboration between health and law enforcement systems at all levels in order to improve health and life stability of IDU and ease their access to prevention, medical and social services
- Development of South African guidelines for the treatment of heroin abuse

Advocacy

- Limited IDU representation due to illegal nature of drug use

Opportunities

Policy

- NSP 2007–2011 identifies IDU as in need of special attention and this NSP should form the framework upon which improvements are made to further specify what research and which programmes should be implemented and how their progress and impact will be measured

Programming

- The IDU TWG has the potential to oversee a coordinated national response to drug use and prevention
- The Western Cape Blueprint to Substance Use provides a good framework to model expansion of multi-sectoral responses to drug use
- Targeting of key populations, including IDU, is a recommendation by several multinational funding bodies, with ring-fenced funding which could be accessible

- Finalisation and implementation of the Prevention and Treatment of Substance Abuse Bill is required, and should incorporate harm reduction as a philosophy, to include NSE and OST as part of a holistic approach to managing IDU
- There is currently no requirement for specific accreditation of mental health and health professionals in the field of substance use
- Punitive laws related to possession of small quantities of drugs should be abolished in order to relieve the law enforcement systems (police, courts and prisons) and to allow for drug users to access services without the risk of being arrested

Programming

- The lack of a mechanism to measure service needs
- Discrimination of IDU by health workers
- The lack of IDU-inclusive BCC campaigns to provide prevention messaging and to counteract misperceptions and myths regarding risky behaviours
- Limited coordination of programming
- Community outreach to IDU is limited
- No widespread implementation of holistic intervention inclusive of pharmacological interventions (OST/maintenance therapy) and NSE programmes where required
- Provision of integrated IDU, HIV and mental health services
- Lack of state halfway houses
- Lack of specialised services for IDU in the prison system
- There is a lack of appropriate services after discharge from substance treatment centres (aftercare programmes)
- Training of health workers in order to reduce stigma, improve confidentiality and improve trust between health workers and drug-using patients
Challenges

- Continued focus on abstinence programmes despite evidence emphasising effectiveness of harm reduction philosophies
- Difficulty associated with effective treatment of IDU, particularly heroin
- Unregulated provision of heroin dependence treatment may be an inefficient use of resources with a poor outcome
- Threat of policies not being backed with sufficient funding resources, not being fully implemented and/or not being monitored
- Increase capacity of relevant government structures to implement and monitor registration of treatment centres
The practice of sex work* is an ancient practice which exists around the globe, despite legislation which makes sex work illegal. In fact, demand and opportunities for sex work are expanding globally, potentially due to international changes in socio-economic and political conditions.\(^\text{20, 138, 139}\) SW are a diverse group of individuals and include men, women and transgender adults (with a strong overlap with cross-border and internal migration) who receive money or goods for consensual sexual services. Sex work can take many forms – and may range from SW working as independent contractors to situations where there are intermediaries between SW and their clients, as well as from occasional to full-time employment as a sex worker.\(^\text{4}\)

Sex work is widespread throughout South Africa and is influenced by several social and economic factors. Important economic factors that impact on the sex work industry include the need for individuals to provide livelihoods for themselves and their dependants, and the on-going demand for paid sex.\(^\text{140}\) Incentives associated with sex work and the monetary worth placed on services in contemporary society lead many people to choose sex work as an occupation, or to supplement their income. Poverty, limited education and gender inequality are social factors which limit the options available to many South Africans, particularly women, and may make sex work a viable option for survival and the only opportunity to provide for themselves and their dependants.\(^\text{138, 139, 141}\)

Despite initial studies revealing high HIV prevalence among SW, limited research has been conducted among this population. Only 1% of abstracts submitted to the South African AIDS Conferences between 2003 and 2009 (22/1939) were related to sex work. These abstracts highlighted violence, poor working conditions, rape, barriers to safe sex, stigma and health as key issues affecting SW in South Africa.\(^\text{142}\) Only 2% of abstracts accepted to the 5th South African AIDS conference and 4% of accepted abstracts for the 1st International Social Science and Humanities Conference on HIV related to sex work.\(^\text{143}\)

In contexts where sex work is illegal, SW’ human and constitutional rights are often violated – in particular their rights to freedom, access to health care and non-discrimination.\(^\text{5, 20, 23, 97, 141, 144-149, 150}\)

Where the rights of SW are not ensured, they are often subjected to a range of human rights abuses, including sexual and other types of violence, often at the hands of the police, extortion by managers of brothels and unlawful arrest. Discrimination by health care providers, and community and family members is also common, often leading to long-term psychological consequences. Most importantly, in contexts where sex work is criminalised, SW do not have options for legal recourse nor access to appropriate support structures.\(^\text{21, 34, 146-147, 151, 152}\)

Many SW are also at increased vulnerability to HIV infection and its effects as a result of multiple individual as well as social factors, described below. Structural and legal reform is needed to ensure that the rights of SW are realised.\(^\text{153, 154}\) Within some concentrated epidemic settings, interventions focused on SW and their clients have been effective in reducing incident infections, and increased SW focused interventions are needed within generalised HIV epidemic settings.\(^\text{20}\)

The diversity of SW should be taken into account when developing solutions to address SW vulnerability to HIV. A recent explorative study on men who sell sex from southern Africa provided insights into the complexities of male sex work, and the role of resilience in how sex work not

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* Sex work is a non-judgemental term used to refer to sex between consenting adults over 18 years of age, either regularly or occasionally, formally or informally, for cash, kind or services, where the person selling sex may or may not self-identify as selling sexual services.
only provided a means for survival but also plays a positive role for many people, and how the power dynamics and prejudices of contemporary-society influence create barriers to the realisation of personal potential. Additional studies have been conducted in several ‘hotspots’ to estimate the number of MSM engaged in sex work. These studies estimated there to be 496 (95% CI 437–555) MSM sex workers in Johannesburg and 612 (95% CI 61–1163) in Durban.

The exchange of sex for monetary or other gain has been documented to be common practice in South Africa, and is influenced by societal and individual factors which place women and men at increased risk for HIV. Over 20% of women interviewed in a Soweto study reported having ever had sex with a non-primary male partner in exchange for material goods or money.

Case study

“I became infected with HIV as a result of a rape. In 2004, I was coughing and losing a lot of weight so I decided to go to get tested. It was during this time that I found out that I was HIV-positive. When the nurse at the clinic told me about my status she announced it to me in the hallway, in front of everyone. I felt angry and embarrassed that she did this, and at the time, I did not realize that I could report her. Fortunately, my experiences with health care services have improved after this experience!

At that time, I did not know anything about what it meant to be HIV-positive. I did not know what I needed to do to take care of myself. All I remember was that I felt a lot of fear, and that I was reluctant to start ARV treatment. When I look back at that time, I can say that being humiliated in front of people at the clinic did not help me to want to learn more about my treatment options. All I knew was that I was not ready to go on ARVs so instead I took vitamins and tried to eat lots of fruits and vegetables.

In 2008, I became a peer educator. I helped educate other sex workers about prevention, STIs, and encouraged them to come for support services for sex workers. During this time, I began to learn more about HIV and I realized that my life was not over because of my status. I learned that I could be healthy and live a long life. In 2009, I began ARV treatment. I was ready. Because of the support services of Sisonke*, the caring nursing staff at the Sex Worker Project, and my work as a peer educator, the stigma of being HIV-positive was replaced by my desire to live a healthy life.

Although my family does not know that I am a sex worker, or how I contracted HIV, they are very supportive of me as a woman living with HIV. Both of my parents work as hospice workers with people living with HIV so they understand what it means to be HIV-positive better than a lot of people. They really encourage me to stay healthy and take my ARV treatment. This kind of support is wonderful and I feel blessed to have them in my life. I think that it would be much harder if my family were not supportive. When I am not feeling well I go back home so that I can rest and recuperate and this makes a big difference in my life.

As a sex worker, I make sure that I am protected and protect my clients by wearing condoms — after all — My Body is My Business! When there are clients that don’t want to wear a condom I use a female condom. Many clients do not know about STIs so when I see that one of them has an STI, I encourage him to go to the clinic to get tested. Sometimes they tell me that they are afraid, and other times, they tell me that they don’t care about their health. I, myself, have gone with clients to the clinic so that they can get tested for HIV. I support them by accompanying them to the clinic because I know from experience that it is not easy to go alone.

I have been taking ARVs for two years now, and while at times the side effects are hard to deal with, I take them anyways. I am also working as a peer educator and continue to educate other sex workers about health and human rights issues and why it is so important for sex work to be decriminalised. Many sex workers are afraid to get tested because the stigma of being a sex worker is so high, and because they are scared that health care workers may discriminate against them. As a peer educator, a sex worker, and a woman living with HIV I have the opportunity to challenge some of the myths of HIV by sharing my personal story.

*Sisonke Sex Worker Movement is an organisation in Hillbrow, South Africa that is an SW-led movement, launched in 2003. The movement aims to unite sex workers, improve living and working conditions, and advocates for equal rights for SW.
and telling others – specifically sex workers – that they should not be afraid to test for HIV and to seek treatment.

It is my hope that my story serves as an example of the ways in which sex workers are supporting one another, and how sex workers are uniting. My story is just one example, but it is my wish that it positively impacts social and political change for sex workers, and that more sensitive and non-judgemental health services will be rolled out in South Africa.*

HIV Epidemiology of SW

As with other key populations, there is limited research around sex work in South Africa. Initial studies were conducted among SW working along truck routes in KwaZulu-Natal, in mining communities and among SW in Hillbrow, Johannesburg. Studies have identified HIV prevalence among SW to be 44–69%. HIV incidence of 7.2 (95% CI 4.5–9.8) per 100 person-years was documented among mostly SW participating in an HIV prevention trial.159 It has been estimated that up to 20% of new HIV infections in South Africa (2010) were related to sex work. SW, their clients, and the partners of their clients were estimated to contribute 5.5%, 11.5% and 2.8% of new infections respectively. The same study estimated there to be 132 000 female SW in South Africa for the same year. These estimations are reflective of the lack of supportive structural and social environments for SW in South Africa.37

Table 4: HIV prevalence among SW (data for females unless specified)

<table>
<thead>
<tr>
<th>Study location</th>
<th>Date</th>
<th>HIV prevalence</th>
<th>Sample size</th>
<th>Methodology/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>KwaZulu-Natal</td>
<td>1996–1997</td>
<td>50%</td>
<td>145</td>
<td>Cross-sectional survey among SW operating at truck stops.160</td>
</tr>
<tr>
<td>Midlands</td>
<td>1996–1999</td>
<td>56%</td>
<td>472</td>
<td>HIV prevalence obtained from SW screened for HIV-positive cohort study.161</td>
</tr>
<tr>
<td>Johannesburg</td>
<td>1998</td>
<td>45%</td>
<td>247</td>
<td>SW recruited by outreach workers.162</td>
</tr>
<tr>
<td>Carletonville</td>
<td>1998</td>
<td>69%</td>
<td>121</td>
<td>Cross-sectional surveys conducted among different population groups in the community – data provided on SW.156</td>
</tr>
<tr>
<td>Cape Town, Durban and Johannesburg</td>
<td>2001</td>
<td>66% black, 18% white and 17% coloured</td>
<td>249</td>
<td>Cross-sectional survey and oral HIV testing.164</td>
</tr>
<tr>
<td>Durban</td>
<td>2004</td>
<td>60%</td>
<td>775</td>
<td>Screening procedures for an HIV prevention trial – 79% of sample self-identified as SW. HIV sero-incidence rate of 7.2 (95% CI 4.5–9.8) per 100 person-years.159</td>
</tr>
<tr>
<td>Cape Town, Durban and Johannesburg</td>
<td>2005</td>
<td>34%</td>
<td>67</td>
<td>A rapid assessment conducted among drug-using SW – 60% of sample were female; 75% of sample agreed to HIV testing122</td>
</tr>
<tr>
<td>Johannesburg</td>
<td>2010</td>
<td>26%</td>
<td>343</td>
<td>HIV prevalence among SW attending sexual and reproductive health services at brothels and mobile services provided for SW.165</td>
</tr>
</tbody>
</table>

* "Sex Work & HIV" story provided by Elsa Oliviera, accepted for publication in Equal Treatment.
**Risk Factors Affecting SW**

**Structural factors**

Structural barriers influencing SW vulnerability to HIV in South Africa include a robust legal framework that criminalises all aspects of sex work, high unemployment rates and socio-economic status, barriers to accessing services and justice, and prejudicial health care workers, among others.

**Legal framework**

South Africa follows the model of total criminalisation of sex work. The Sexual Offences Act of 1957, the Criminal Law (Sexual Offence and Related Matters) Amendment Act of 2007 and municipal by-laws prohibit sex work and its related activities.\(^5\)

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**Figure 6: Vulnerabilities for HIV facing SW**

<table>
<thead>
<tr>
<th>Vulnerabilities</th>
<th>Current situation in South Africa</th>
<th>Potential effects of decriminalisation and provision of public-sector services for HIV prevention in sex work settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted access to health services</td>
<td>Lack of specialised services targeting SW</td>
<td>Formal SW clinics and outreach, with active follow-up services</td>
</tr>
<tr>
<td></td>
<td>Scanty and ineffective public and donor funding for HIV prevention in sex work settings</td>
<td>Public funding for HIV prevention in sex work settings, and government-led coordination of services</td>
</tr>
<tr>
<td></td>
<td>Condom availability in general primary health clinics, but limited promotion of condoms in sex work settings</td>
<td>Targeted condom promotion and provision in sex work settings</td>
</tr>
<tr>
<td></td>
<td>Syndromic treatment of symptoms within general STI services</td>
<td>Targeted STI control programmes with STI screening at pre-specified intervals, periodic presumptive treatment and syndromic management</td>
</tr>
<tr>
<td></td>
<td>Limited access to health information and family planning counselling High rates of unintended pregnancy; increasing number of dependents</td>
<td>Planned health promotion activities, with information provision, family planning counselling and contraceptive services</td>
</tr>
<tr>
<td>Restricted access to legal protection</td>
<td>Laws against gender-based violence are seldom enforced and police do not act on SW complaints</td>
<td>SW have legal recourse to redress violence Enhanced ability of police to improve the safety of sex work settings</td>
</tr>
<tr>
<td>Unsafe work conditions</td>
<td>Unsafe venues</td>
<td>Enhanced ability to secure and control sex work settings</td>
</tr>
<tr>
<td></td>
<td>Obtaining clients and negotiation often occur in settings where alcohol is served</td>
<td>Alcohol and paid sex can be delinked</td>
</tr>
<tr>
<td></td>
<td>Difficulties in negotiating safe sex</td>
<td>More empowered SW enables condom negotiation and client refusal</td>
</tr>
<tr>
<td>Stigma</td>
<td>Judgmental health care workers</td>
<td>Specialised health care workers, trained in sensitive provision of services</td>
</tr>
<tr>
<td>Economic vulnerabilities</td>
<td>Despite the threat of fines or imprisonment, women enter sex work in response to the demand for paid sex and the pressures of providing for dependents, as they have few alternatives</td>
<td>No evidence that decriminalisation will increase supply of SW or demand for sex work</td>
</tr>
</tbody>
</table>

Source: Richter et al., 2010
The economic, social and physical vulnerability of SW is perpetuated by laws criminalising sex, yet despite these structural barriers large numbers of South African men and women are involved in sex work. The constitutional pillars of dignity, freedom and equality are undermined by these laws. So too are the constitutional rights to access food, water, social security, education, health care and freedom from discrimination.\textsuperscript{5, 21, 141, 146, 151, 166, 167}

Many sex work organisations in Africa have made submissions to the UN Commission on HIV and the Law on the impact of the criminal law on sex work, including a submission from the Sisonke Sex Worker Movement (South Africa).\textsuperscript{144}

### Legislation around sex work in South Africa

Currently sections 20(1)(aA) of the Sexual Offences Act of 1957 and section 11 of the Criminal Law (Sexual Offence and Related Matters) Amendment Act (2007), and various municipal by-laws constitute the legal framework which criminalise sex work in South Africa.

Section 20(1)(aA) criminalises sex work. This section penalises the practice of sex work as well as sex-work related activities such as the keeping of brothels, living off the earnings of sex work and the procurement of SW.

The Criminal Law (Sexual Offence and Related Matters) Amendment Act section 11 is a recent amendment to the act which, in addition to revising the definitions of sexual violence, allows for the prosecution of the clients of SW.\textsuperscript{168}

### Municipal by-laws

Municipal by-laws expand on the national legislation in each province and relate to traffic obstruction, loitering and other clauses. Municipal by-laws are commonly enacted and used to arrest and control sex work in municipal areas.\textsuperscript{144, 147, 169}

The limited access to health services and increased vulnerability to HIV/AIDS that result from the criminalisation of sex work affects health promotion, prevention and treatment interventions from the foundation of public health, and arguments supporting the decriminalisation of sex work. Ongoing arrests of SW and their lack of legal recourse further affects their human rights.\textsuperscript{5, 21, 146, 151, 170}

### Laws criminalising clients

The section explicitly criminalising clients of SW was reported to be included without appropriate evidence-based research to support its inclusion, and was introduced after the period for public consultation had ended. Wording of law allows for government to intrude into consensual sex between adults.\textsuperscript{166} Most women engaged in sex work do so for economic reasons and many actively seek clients. Criminalising clients increases the vulnerability of SW as they are forced to work in more dangerous and more compromising situations to mitigate the fears clients have of being arrested.\textsuperscript{5, 21, 149, 170} Where criminalisation of clients has been instituted there has been no evidence of an impact on sex work activity or HIV incidence, and it has increased the vulnerability of SW who continue to provide sexual services.\textsuperscript{141} The Criminal Law (Sexual Offence and Related Matters) Amendment Act has been perceived by SW and SW advocacy groups to harm the women it was meant to protect.\textsuperscript{5, 146}

### Labour law

Because sex work is a criminal activity, South Africa’s robust labour framework does not apply to SW. The absence of legal recognition of sex work results in occupational health issues. SW are often unable to resort to legal recourse in the event of unsafe working environments or unfair labour practices.\textsuperscript{151}

The South African Law Commission began an investigation into sexual crimes against adults in 1997, and in 1998 the Commission on Gender Equality produced a position paper which recommended the decriminalisation of sex work. The South African Law Reform Committee (SALRC) has subsequently released a discussion paper on four possible options for legal reform with respect to sex work. In the discussion paper, the SALRC only put forward a description of the four options and made no recommendations, which was most unusual for a discussion paper which should usually contain specific recommendations.\textsuperscript{168} Public submissions were requested yet again and at the time of writing this report, the SALRC had still not released any recommendations.

The rights of SW to approach the Commission for Conciliation, Mediation and Arbitration (CCMA), Bargaining Council or Labour Court was secured...
through the successful ‘Kylie’ case (2010). Kylie, a sex worker, was fired from her employment at a brothel in Cape Town. Kylie filed a case of unfair dismissal and the case was eventually heard by the The Labour Appeal Court, which concluded that the illegal activity of a SW does not prevent her/him from enjoying a range of constitutional rights and that fair labour practices does vest in ‘everyone’ in an employment relationship.*

Under apartheid-South Africa, various criminal laws on sexual morality contributed to the disempowerment of non-whites, women, gay and lesbian people and resulted in increased state intervention into individuals’ private lives. In recognition of these human rights violations and South Africa’s racist history, radical legal reform and a democratic constitution based on human rights was developed. The outdated laws that criminalise sex work require urgent law reform to ensure that the rights of SW are protected. National legislation must be enacted to prevent such discrimination and guarantee that the constitutional pillars are ensured for all.21, 146, 149, 166

**Social factors**

Many of the societal influences which increase SW vulnerability to HIV are related to poverty, low levels of education, high unemployment rates, barriers to accessing health care and gender inequality.5, 146, 155, 156, 163, 171, 172 These issues need to be addressed if South Africa is to meet the United Nations Millennium Development goals of eradicating poverty and hunger, achieving universal primary education, reducing child mortality, improving mental health and combating HIV and infectious diseases.130, 147, 149, 153, 173

Stigma and discrimination towards SW by health providers, as well as breaches in confidentiality are some of the barriers which prevent SW from accessing health services.20, 144, 148, 171, 174, 175

Police are responsible for a wide range of violence and abuse of power towards SW. In addition to the lack of protection provided to SW, instances of bribery, violent threats and rape have been reported. Reports have also been made of police seizing and burning condoms distributed to SW and of police arresting SW when they find condoms on their person.21, 144, 146, 147, 148, 192, 176, 177

Gender inequality and overarching gender-based power issues limit the ability of SW to negotiate condom use and disempowers them to access health and social services. Power inequities also contribute to the high prevalence of sexual assault, battery and rape by partners or strangers.30, 136, 147, 157, 160, 173, 178–181, 181

**Individual risk factors**

A large proportion of SW have been shown to use substances, particularly alcohol and cannabis. Alcohol has also been shown to be associated with decreased ability to communicate around HIV risks. Substance use may also serve self-preserving, coping and self-destructive strategies.122, 126, 132, 135, 164

Victimisation and histories of childhood abuse have been documented among SW and may contribute to the prevalence of low self-esteem and depression seen among many of them.182

Sexual practices including inconsistent condom usage, multiple partners and anal sex have been associated with increased risk for HIV infection among SW.132, 160–163, 174, 183, 184

**Limitations**

The data to date is derived from a limited number of studies, many of which are old. It should be noted that the current HIV prevalence amongst SW may be even higher than the prevalence documented in studies completed in the late 1990s. The current data also fails to represent the heterogeneity of SW and the forms sex work can take in the South African context. There is also limited data on effective interventions to provide HIV services.

**Sex Worker Programming**

**Scope of programming**

Currently no national SW health programme exists despite recommendations in the 2007–2011 NSP. Limited health, advocacy and legal services are provided by a few NGOs which are based in Cape Town and Johannesburg. Less than 5% of SW are estimated to be reached with current HIV interventions.37

Sisonke, an SW-led organisation with branches in Cape Town, Johannesburg, Limpopo and KwaZulu-Natal aims to mobilise SW and provide

* Details provided by personal communication with the Women’s Legal Centre
safe spaces for them, and additionally outreach and condom distribution activities are provided. The South African Sex Workers Alliance (SASWA) is the South African chapter of the African Sex Worker Alliance and made up of individuals and organisations committed to ensuring the rights of SW and the decriminalisation of sex work. Recently, a Sex Worker Decimalisation Working Group was established with the aim to guide the development of sex work decriminalisation in South Africa.\textsuperscript{5}

The only sex-work-specific health care programme is the Essen Street Clinic (Hillbrow) that is linked to the Wits Reproductive Health and HIV Institute (WRHI). In addition to clinic based services, a mobile service exists to provide services to SW in brothels and hotels, as well as street-based SW in Hillbrow.\textsuperscript{16} An evaluation of this project showed that clients perceived the services to be of acceptable quality and highlighted positive changes in health-seeking behaviour and a positive shift in perceptions towards hotels where clinics were provided.\textsuperscript{16} There has also been a continual increase in the number of clients seen since 2002. It is an exemplification of non-discriminatory health service provision and the involvement of SW in developing and implementing programmes. This project has identified high levels of STIs among SW, and experience has shown that long waiting times at clinics and changing locations of work contribute to the high rates of loss to follow-up seen among those infected with HIV, particularly after initial HIV diagnosis.\textsuperscript{16, 17} The cost effectiveness of targeted HIV prevention interventions among SW in areas of high concentration has been shown, and the model for service provision could be used to roll-out interventions across South Africa.\textsuperscript{18}

Behavioural interventions aimed at addressing substance use among female SW have been implemented by Research Triangle International (RTI) in Pretoria, and have shown to be effective in increasing female condom use and reductions in substance use.\textsuperscript{18} Lifeline (Durban) provides outreach and casework with street workers. Private health care clinics also provide health services to SW. The Corridor Empowerment Project and Trucking Wellness provides services in truck stops across South Africa, which have shown increased usage of services since inception.\textsuperscript{18} Services in mining communities in the north western region of South Africa have included SW in community HIV prevention interventions.\textsuperscript{15, 16} Legal service assistance to SW is provided by the AIDS Legal Network, the Women’s Legal Centre and Twaranang Legal Advocacy Centre (TLAC). Advocacy for sex work is supported by the World AIDS Campaign and SWEAT.\textsuperscript{5}

**Sex worker funding**

Currently there is limited funding provided for services targeting SW.\textsuperscript{19} Support for services is provided mostly through funding from international development partners. Access to funding may be limited in the presence of funding requirements pertaining to decriminalisation of sex work, for example organisations obtaining funding from PEPFAR are required to sign a declaration to not advocate for SW decriminalisation. The provincial governments of several provinces provides some support for the services operated by NGOs. International support for service provision is received from The Global Fund, the Ford Foundation, OXFAM and advocacy is provided by the Open Society Foundation of South Africa. Support for pilot interventions with a research basis aimed at SW conducted in collaboration with RTI and local organisations comes from a combination of sources, including the United States National Institute on Alcohol Abuse and Alcoholism, the United States National Institute of Health and National Institute on Drug Abuse. The U.S. Government provides support for some of the services provided through the WRHI. UNFPA and UNDP are the United Nations convening agencies supporting work pertaining to SW and their rights (the list is not exhaustive).

**SWOC Analysis for Sex Workers in South Africa**

**Strengths**

**Data**

- Initial evidence base exists to show high HIV prevalence, barriers to services and the need for SW focused interventions
- Evidence from the Hillbrow SW outreach and mobile services has documented success in accessing SW, increasing service demand and providing services of acceptable quality. Such a service could be modelled for expansion to other areas of high SW concentration
Policy

- The rights of SW are outlined in national policy documents
- SW are entitled to all the human rights provisions in South Africa’s constitution
- The South African NSP 2007–2011 includes SW as a key population and recommends decriminalisation and provision of targeted prevention interventions

Programming

- A limited network of organisations exists with the ability to ensure some advocacy, research, legal reform and service provision can occur. Greater support of the issues are needed
- Best practice models such as mobile clinic services, services along transport routes and peer-led outreach projects exist for scale-up and roll-out

Weaknesses

Data

- No national prevalence data and no recent prevalence data available
- Only initial quantitative and qualitative data exists – more data is needed to better understand contextual issues affecting SW and the impact of HIV
- Limited data on male and transgender SW, and on cross-border migrant SW based in South Africa

Policy

- Law reform processes are underway but are very slow – requires pressure from the health sector
- No implementation of NSP 2007–2011 interventions targeting SW
- Lack of high level support for SW issues and absence of political will

Programming

- Current criminal laws on sex work undermine freedom from discrimination, access to health and the freedom to choose a profession with impunity of perpetrators of violence against SW
- SW specific health services and peer-based outreach are provided in limited areas and do not reach the coverage needed in order to significantly impact on improving access to health for the majority of South African SW

Funding

- Limited and poorly coordinated funding to take programmes to scale
- Current funding restrictions by some international donors limit comprehensive sex work programmes

Opportunities

Data

- Initial data exists, supporting the need for tailored interventions
- Establishment of SW based organisations provide the framework for the development and implementation of research

Policy

- Draft decriminalisation bill under development, led by NGOs
- NSP 2007–2011 provides an outline for policy priorities and SW health services, which are needed. This framework could be used as the basis for the NSP (2012–2016) with increased specificity and accountability mechanisms where appropriate
- Global emphasis on addressing needs of key populations
- UNAIDS recommends the removal of punitive laws and policies that prevent access to comprehensive HIV prevention, treatment and care

Programming

- Sex worker peer education programmes exist and have the potential for expansion to include the provision of condoms, lubrication and information on sex worker rights, HIV and other health related issues.
- Model of mobile services available for expansion
Funding

- National support for sex work has been expressed and the opportunity exists to advocate for the translation of support into action.
- Initial support has been provided by several development partners.
- PEPFAR has removed the prostitution clause allowing for the funding of sex work by U.S. organisations. Additional advocacy and lobbying around this issue may allow for such funding requirements to be removed for South African organisations, so that organisations in support of the decriminalisation of sex work and other human rights-based approaches, would be able to access PEPFAR funding.

Challenges

Data

- No national HIV prevalence data exists, and much existing data is outdated. Accurate data around HIV prevalence and estimated number of SW (sample size) would provide additional evidence in support of focused programmatic interventions. Accurate national level data will also provide baseline information against which the impact of HIV interventions could be measured.
- Available HIV funding may not be diverted to sex-worker related interventions.

- Uncoordinated funding may result in duplication of activities and lessen the impact of interventions.

Policy

- Sexual moralism and resistance to law reform hinders the roll-out of rights-based programmes.
- Translating the South African Law Reform Commission’s review of current sex work legislation into recommendations and subsequent law reform.

Programming

- Limited budget and capacity restricts potential for expansion.
- The lack of SW-led programming and programmes aimed at building the capacity of SW limits the potential impact of interventions.

Funding

- Ensuring dedicated funding for provision of services for SW.
- Removing policies which impose moralistic funding requirements on organisations that prevent SW organisations in support of decriminalisation, from accessing funding, for example PEPFAR’s ‘Anti-prostitution Loyalty Oath’.
At any given time there are approximately 9.8 million persons incarcerated worldwide, hosting approximately 916,239 prisoners. Fifty seven per cent of all incarcerated people are in sub-Saharan Africa, on average 160 per 100,000 population are incarcerated (southern African countries averaging 231/100,000) compared to the global average rate of 145 per 100,000.\textsuperscript{13}

The number of prisoners is growing – between 2007 and 2009, 64\% of African countries reported prison population growth, signifying greater overcrowding in prisons where facilities and resources are already overstretched. South Africa has the highest number of prisoners in southern Africa (413 per 100,000).\textsuperscript{191, 192} An estimated 360,000 move through the South African prison system annually.\textsuperscript{193} The 2009/2010 annual report of the DCS states that at the end of March 2010 there were 164,793 inmates.\textsuperscript{193}

In prisons across the world, the HIV epidemic presents a major challenge. HIV prevalence within prisons is often far higher than in the general community and prisons are a high-risk environment for HIV transmission.\textsuperscript{194} Although there is very little information on both prevalence of HIV in African prisons as well as the nature and extent of high-risk activities for HIV transmission, preliminary data suggests that effective HIV programming is required in order to prevent worsening of the situation.\textsuperscript{13, 14, 103} There is however, ample indication that high-risk behaviours such as unprotected sex, unsafe tattooing, rape, and other forms of violence, drug use (including injecting drug use) and other high-risk activities do take place in African prisons.\textsuperscript{134, 196}

A recent (2009) study in Uganda indicated an HIV prevalence of 11\% in prisons which is double that of the Ugandan population as a whole.\textsuperscript{196} In Mauritius, where IDU appears to be the principal driver of the epidemic, HIV prevalence in prison was 50 times higher than in the community. In regions or in countries where the HIV prevalence is quite low in the general population there tends to be significantly higher HIV prevalence among prisoners.\textsuperscript{197} In addition to HIV, worldwide the prevalence of TB and other communicable diseases are generally higher within prison populations than in the general population. Many inmates also arrive in prison at already greater risk to STIs or experiencing compromised health.\textsuperscript{13}

Prison environments provide an opportunity for the provision of HIV prevention, treatment, care and support services for individuals at increased risk of HIV acquisition and the effects of infection.\textsuperscript{198} Prisoners’ health is public health, and the WHO and UNODC recommend the provision of comprehensive HIV programmes within correctional institutions as informed by current evidence.\textsuperscript{195}

Case study

Prison rape frequently occurs when a newly arrived inmate accepts food, drugs or protection from another prisoner who pretends to be concerned for the newcomer, who is usually terrified and overwhelmed. The newly arrived inmate will most often assume that this is simply a gesture of support. However, according to the ideas and ways of doing things that are accepted and endorsed by the dominant inmate culture and power structures, by eating the food or smoking the cigarette, a debt has now been created. The new naïve offender will only later learn that he is expected to pay back this debt with sex. And when he tries to refuse, he will learn that he has no choice in the matter. This scenario, which plays out frequently, shows up vulnerability of the new first time offender who is oblivious of unwritten ‘rules’ of inmate culture. He has no idea of the supposed ‘debt’ he’s been tricked into by accepting the food or a cigarette.
Another context in which inmates are at high risk of sexual violence is in communal prison cells overnight during ‘lockup’, when prisons operate with a minimal staff and inmates are left to fend for themselves. In many such instances victimised inmates do not receive any assistance until the following morning when the cells are opened and staffing levels return to normal.

The pervasiveness of rape in South African detention facilities is directly linked to the nation’s HIV/AIDS crisis. With so little being done to prevent sexual abuse and to educate inmates and staff about HIV, the sexual transmission of HIV behind bars will continue to be a major problem with serious ramifications for detention facilities as well as the communities most inmates ultimately return to.*

**HIV Epidemiology of Prison Populations in South Africa**

Accurate data on HIV prevalence within the South African prison system is limited. Available data may not be reliable due to the biases caused by conducting research within the hostile prison environment and the inconsistent manner in which data has often been gathered.\(^{201}\)

Initial estimates from an HIV prevalence study conducted in 2002 were not made public. Projections based on this data estimated national HIV prevalence within the prison system to be approximately 41%.\(^{200}\) The DCS reported HIV prevalence among inmates to be 19.8% in 2006 and 22.8% in 2009. However, this is based on VCT and treatment access suggesting that HIV prevalence may in fact be higher. South Africa (through the DCS) has made great strides in addressing various aspects of HIV in prisons, including condom availability, VCT and ARV treatment. Sentenced offenders reportedly have 100% access to primary health care services. In 2010, over 72,000 inmates attended HIV awareness sessions and there were over 100 functional support groups, with 12 accredited ART sites and over 7,500 prisoners on ART.\(^{193}\)

Despite this progress, there is still a need for an HIV prevention revolution in the correctional centres so as to prevent new infections whilst under incarceration.

**Risk Factors for HIV Among Prison Populations**

**Structural factors**

Overcrowding, high population turnover and unhygienic conditions contribute to the spread of infectious diseases within correctional service institutions.\(^{195, 197}\) Research has also shown that many staff in detention facilities are not adequately supported, trained or equipped to promote the sexual health and rights of inmates, and to prevent

* A case-study for a prisoner was not possible. This scenario reflects vulnerabilities within the prison services and the role played by the Sexual Offences Act within detention facilities – provided by Sasha Gear and Cynthia Totten from Just Detention.

### Table 5: HIV prevalence among prisoners in South Africa

<table>
<thead>
<tr>
<th>Location</th>
<th>Year</th>
<th>HIV prevalence</th>
<th>Sample size</th>
<th>Methodology/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>2009–2010</td>
<td>22.8%</td>
<td>HIV testing available to all sentenced prisoners, on average 360,000 per year</td>
<td>Data from only 47,011 HIV tests provided(^{193})</td>
</tr>
<tr>
<td>National</td>
<td>2006</td>
<td>19.8%</td>
<td>8,649 (only 5,299 participated)</td>
<td>Cross-sectional survey targeting 10% of sentenced prisoners. Low participation rate (46.4%)(^{199})</td>
</tr>
<tr>
<td>National</td>
<td>2002</td>
<td>41%</td>
<td>Modelled projection</td>
<td>Projection of HIV antenatal prevalence data to prison population, assuming prevalence among prisoners to be twice that of the general population, matched by gender and age(^{200})</td>
</tr>
</tbody>
</table>
and respond to the health needs, including those related to sexual abuses, of prisoners.\textsuperscript{202} In South Africa, the lack of health care capacity in the correctional service system limits health service coverage. Many sexual and reproductive health services are provided off site, requiring additional resources and limiting coverage. In addition, they are for vaginal rather than anal sex. Consistent condom availability is a problem and condoms are provided without lubrication.\textsuperscript{134, 193, 203–205}

**Social factors**

Many prisoners come from relatively marginalised, poor, unstable and poorly educated environments, and as a result may be at increased vulnerability to HIV infection before entering correctional centres.\textsuperscript{13, 194, 195}

Sex, both consensual and forced, takes place within the prison environment. Due to prevailing inmate and institutional culture, sexual violence has become normalised and is often incorrectly perceived as an inherent aspect of prison life.\textsuperscript{69, 206} Male prisons tend to be gendered in that some male prisoners manage to earn respect in inmate culture as ‘men’, while others are seen as feminised and are humiliated and abused as a result.\textsuperscript{208} Prison culture tends to be intensely misogynistic and upholds a brutal notion of masculinity, which endorses violence whilst stigmatising victims of sexual violence as having lost their ‘manhood’. This stigma is central to the challenges faced in addressing sexual violence in prisons and against men generally, and is one of the reasons militating against reporting. Sexual violence is built into gang hierarchies and rituals and appears to be evident in most South African correctional facilities. Amongst people living and working in prison there seems to be a lack of clarity around when sex is consensual and when it is coerced – which contributes to neither being appropriately dealt with. The taboo surrounding homosexuality and sexual violence against men is a key obstacle to promoting safe sex and preventing sexual violence in prison.\textsuperscript{134, 202}

**Individual factors**

Substance abuse has been associated with increased vulnerability to HIV infection and is believed to be under-reported within correctional services. Despite the best efforts of prison authorities to prevent the entry of drugs into prisons, drug use does exist amongst prisoners worldwide and South Africa is not believed to be any exception. Interviews with ex-prisoners have informed us of the South African prison context and the roles gangs play within the prison system. Drug supply, distribution and consumption is reported to be under the control of gangs, despite existing controls on substance use within correctional facilities. In a recent global review article on prisoners and HIV, IDU within South African prisons were reported as being ‘not common’.\textsuperscript{13, 134}

High-risk behaviours such as URAI and rape have been reported in detention centres.\textsuperscript{206} The sharing or reuse of tattooing and body piercing equipment, the sharing of razors for shaving and the use of non-sterile equipment occur in correctional settings globally, which may ultimately lead to new HIV infections.\textsuperscript{13, 195}

Poor knowledge and misperceptions around HIV transmission also jeopardise inmates’ sexual health. For example, two-thirds of juvenile inmates surveyed in a Gauteng institution did not know that Vaseline, which is widely used by inmates as a lubricant, damages condoms.\textsuperscript{134}

While no inmate is immune from the potential danger of rape and other forms of sexual abuse, certain characteristics make some inmates particularly vulnerable to sexual violence and result in an increased likelihood of exposure to HIV infection.\textsuperscript{208}

**Programming**

HIV services within detention centres:

In 2010 there were 12 accredited sites, 7,640 inmates were on ART, 72,227 inmates attended HIV awareness sessions, there were 103 functional support groups, 14% of the offender population participated in comprehensive HIV and AIDS programmes and sentenced offenders reportedly had 100% access to primary health care services. Relevant policies around ART provision, PEP and HCT were reported to have been distributed.\textsuperscript{193}
Prisons have been identified as strategic points to increase access to HIV prevention, treatment, care and support services to offenders. Additional focus needs to be placed on prevention programmes and for the utilisation of peer-led programmes.  

**UNODC and DCS Planned Prison Projects: 2012–2016**

1. Conduct an HIV and IDU prevalence survey in prison settings in South Africa
2. Roll-out the programme on ‘Drug Abuse Prevention and HIV and AIDS Awareness Creation among Juvenile Offenders in South African Prisons’ in additional 10 prisons
3. Strengthen HIV prevention, treatment, care and support through UNODC-supported programme to be started in January 2012

**SWOC Analysis for Prison Populations in South Africa**

**Strengths**

**Research**
- Preliminary surveys have been successfully implemented – repeated sampling will inform trend analysis

**Policy**
- Policies in place pertaining to holistic HIV prevention, treatment, care and support services
- UNODC and WHO guidelines exist for improved HIV services for inmates

**Programmes**
- Initial data exists on disproportionate HIV prevalence among inmates
- Improved strategic plan includes HIV as a key component of care program

**Weaknesses**

**Research**
- Poor levels of participation in research and hostile prison environment may affect validity of data

**Policy**
- Limited implementation of policy

**Funding**
- Funding currently limited to that received from government

**Programming**
- Human resources gaps
- Individuals not yet sentenced unable to access HIV services

**Opportunities**
- Opportunity for provision of HIV information and sexual and reproductive health services
- Policies for the provision of comprehensive HIV programmes exist, thus the framework exists for the implementation of such programmes

**Challenges**
- Expanding coverage of services
- Addressing high incarceration rates
- Addressing overcrowding and improving infection control
- Increasing access to condoms and HIV testing
- Addressing human resource needs
- Obtaining accurate national estimates around HIV
Migration is a global phenomenon, which is key to the development of individuals and society. In order for the benefits of migration to be realised it should be managed in a healthy way. Migration has played a vital part in the development of southern Africa, often influenced by socio-political factors.

South Africa has been long associated with the movement of people – historically, most cross-border migration was related to labour migration within the agricultural and mining sectors. Migration into South Africa has consistently increased since the end of apartheid.

Within the region a circular pattern of migration exists, with many people returning to their place of birth after a period of time. Evidence indicates that migrants will return home if they become too sick to work and research indicates that sickness due to HIV and TB are the main causes of this return migration. Such return migration in times of sickness places burdens on the sending area which is often rural.

It is estimated that in 2010 there were approximately 2.2 million migrant people in southern Africa, a 7.3% increase since 2005. South Africa hosts the majority of migrants in the region (1.9 million) and, due to economic opportunities locally and socio-political instability in neighbouring countries, it is poised to continue to experience such growth in migrant populations.

Both internal and cross-border migration are important aspects for consideration in national HIV response development. Efforts aimed towards addressing issues affecting migrants should be viewed from within a spatial context, whereby spaces of vulnerability can be identified and interventions developed. Data shows that often migrants are in better health than resident population groups when they arrive in their destination area. It is the context in which migrants find themselves that can increase their vulnerability to acquiring HIV and their risk to the consequences of HIV infection.

The linkages between rural and urban areas and cross-border migration have been identified as being critical areas of concern relating to health issues. Migrants face multiple barriers when accessing services, which may increase vulnerability to the effects of HIV and related diseases.

Case study

“I am a Zimbabwean citizen and have been in RSA for about 4 years.

I have a bad and good experience to share when it comes to health care access in the [R]epublic of South Africa.

On the side of the Good side of the story is that, when I arrived in the Republic Of South Africa, I did not get much problem continuing with my ARVs. I came from Home, I was on treatment there, when I arrived here, I went at the Clinic to ask about getting medication, I was just told that I need to get tested again HIV as well as CD4 Cells which I did, and from there after providing the card showing my treatments back home, I was put back on treatment and carried [on] with my treatment on the south African system.

On the other hand this is the sad story -something happened, and I couldn’t understand, but the truth of the matter is that I started developing some side effects because of the medication I was on. I started loosing my sense of hearing and that went on and on. when I went for check ups, I was told that is just the side effects; it will pass, but yet I could feel that it was going worse and until I completely couldn’t hear again.
Then I went to see the doctor specifically for that issue, and he confirmed that I am having problems with my ears. Then I went back to the hospital where I usual go in regards of my HIV treatment, when I told them the story, they said they can not deal with it. I have to take care of it on my own which I can’t.

So now I am deaf I can’t afford to pay the treatment on my own.” *

HIV Epidemiology of Migrant Populations in South Africa

The relationship between migration and HIV is complex. Migration has been shown to increase vulnerability to HIV, for both migrants and their partners who remain behind and different migratory processes are associated with different vulnerabilities to HIV acquisition.\(^{11, 213, 214}\)

Since the early stages of the epidemic, infections in rural areas have been traced to those who had been in urban areas.\(^{215}\) HIV prevalence levels have been higher along roads\(^{216}\) and truckers have been found to be at higher risk because of their greater mobility.\(^{217}\) Also, South Africa shares its borders with six countries, all of which exhibit some of the world’s highest levels of HIV prevalence.\(^{218}\)

The link between migration and positive HIV status in South Africa has been demonstrated by several researchers. In 1992 in KwaZulu-Natal migration increased infection risk by almost three-fold for women and seven-fold for men.\(^{219}\) Zuma et al. showed a 60% higher odds of HIV infection in migrant vs. non-migrant women in the Carletonville mining area (2003)\(^{220}\); Lurie et al. showed migrant men from Hlabisa and Nongoma Districts in KwaZulu-Natal to be 2.4 times more likely than non-migrant men to be HIV-infected (2003)\(^{214}\) and Bärnighausen et al. showed migration to be significantly associated with HIV incidence in KwaZulu-Natal (adjusted Hazard Ratio migrant vs. non-migrant: 0.48) (2007).\(^{221}\)

Overall, the data shows that labour migration leads to risky living contexts and behaviours, with couples living apart and finding secondary partners.\(^{37}\)

Data from a longitudinal HIV surveillance study in rural South Africa shows that migrants face almost twice the risk of acquiring HIV compared to non-migrants when adjusting for the common demographic and socio-economic factors (sex, age, education, wealth, household expenditures and place of residence).\(^{221}\)

However, it is important to emphasise the bi-directionality of migration and HIV infection – it is not only those who migrate who are found to experience an increased vulnerability to HIV as a result of the migration process. A prospective study conducted with internal migrants in rural South Africa showed that in almost one-third of discordant couples, it was the female partner who ‘remained at home’ that was infected with HIV.\(^{214, 202}\) These findings challenge the prevailing assumption that HIV is spread only by male labour migrants who ‘become infected’ in urban centres (within a country or across borders) and then return home and infect their partners in the rural areas.\(^{210}\)

It is imperative for the South African HIV response to engage with migration and address the vulnerabilities faced by many migrants, including those in large urban areas.\(^{202}\)

Risk Factors for HIV Among Migrant Populations

**Structural factors**

The pattern of working in one place and having a main/family residence in another place impacts on the stability of relationships and family structure. In 2009, 16% of individuals aged 25–55 said that they live away from their primary sexual and relationship partner.\(^{37}\)

Many of the underlying factors sustaining migration, such as an unbalanced distribution of resources, lack of social capital, unemployment, socio-economic instability and political unrest, as well as overcrowded living conditions, discrimination in accessing health services and a lack of adequate nutrition are also determinants of the increased risk of migrants and their families to ill health. Limited access to services due to a range of legal, economic, language, social and cultural factors, for example access to services after working hours in remote and underserved areas. Migrants also often work under dangerous working

* “My South African Experience” documented by Pascal Manini.
conditions – all impacting on migrants’ health status. For cross-border migrants, the lack of interlinked services and compatible health information systems mean that continuing treatment and continuum of care for migrants is often impossible.21, 224, 226 Key structural factors increasing the risk of HIV infection among migrants include:

- Socio-economic situation and unemployment in rural areas;
- Mobility as primary livelihood strategy;
- High levels of gender inequality;
- Lack of migrant health policies and guidelines;
- High population mobility; and
- Cultural factors

An additional problem is the inability of many lower-skilled international labour migrants to obtain the necessary documentation to be in South Africa legally due to (1) a restrictive immigration policy and (2) poor implementation of this policy.21, 226 In addition, access to documentation through the Department of Home Affairs is problematic for all international migrants, including refugees and asylum seekers.21, 226

Social factors

- Epidemiological profile and how it compares to the profile at destination
- Lack of access to health services
- Lack of targeted and appropriate health information
- Challenging working and living conditions
- Gender norms
- Linguistic, cultural and geographic proximity to destination

This has implications not only for international migrants but also for undocumented South Africans. Additional guidelines have been developed in collaboration between the Southern African HIV Clinicians Society and the United Nations High Commissioner for Refugees (UNHCR), supplementing the National Department of Health (NDoH) ART guidelines, to guide ART provision for international migrants, asylum seekers and refugees.227 As a result of the lobbying of civil society groups and the UNHCR, a more recent (September 2007) financial directive from the NDoH confirms that refugees and asylum seekers, with or without a permit, have the same right as South Africans to access free basic health care and ART in the public sector.210

Despite the development of these policy guidelines and frameworks, and although they have been developed relatively recently, many challenges continue to be experienced by international migrants when they attempt to access public health services in South Africa, as protective policy has not been effectively transformed into protective practices.224, 226, 228, 229

International migrants struggle to communicate with health care providers (translators are not present), and some public health facilities have been found to generate their own guidelines and policies that counter national legislation by continuing to demand South African identity documents and denying access to international migrants.210, 226, 230, 231

Individual factors

- Pre-migratory events and trauma
- Low level of knowledge on health and low health-seeking behaviour
- Precarious legal status and limited access to services
- Behavioural and health profiles as acquired in host community
- High health vulnerability during migration process (travel conditions/mode)

Programming

The International Organization for Migration (IOM) provides a wide range of interventions focused on addressing the needs of migrants and the communities in which they exist. Table 6 below provides an overview of these programmes.

Funding

Funding has mainly been received from external donors such as PEPFAR and SIDA. Since 2007, the total contribution to the programme has been approximately US$7 000 000
Table 6: Representation of IOM programming around HIV and mobility

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Rationale</th>
<th>Key interventions (including, but not limited to, the information below)</th>
<th>Geographic area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery and capacity building</td>
<td>Existing ongoing Ripfumelo project</td>
<td>Based on the health promotion and service delivery model, Behaviour and communication campaign, Gender, Documentation, sharing good practices and lessons learnt</td>
<td>Continue with Limpopo and Mpumalanga provinces, Explore opportunities in KZN and FS</td>
</tr>
<tr>
<td></td>
<td>A need to strengthen implementation due to increasing influx of cross-border migrants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy for policy development</td>
<td>Government has started developing policy framework on addressing health issues in the context of migration (the Concept Note on Cross-border Initiative)</td>
<td>Capacity building and technical assistance to government, Technical review of key documents such the National Strategic Framework on HIV and AIDS, Promoting dialogue on health migration, Awareness-raising on migrants’ rights to health.</td>
<td>Priority districts, including Vhembe, Mopani and Enhlazeni, Work with the relevant units within the Department of Health (international liaison)</td>
</tr>
<tr>
<td></td>
<td>Mainstreaming migration health into district health plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and information dissemination</td>
<td>Huge gap in knowledge on migration dynamics within the country</td>
<td>Integrated Behavioural and Biological Surveys (IBBS), Other qualitative research such as hotspot mapping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need to understand impact of specific health issues such as HIV, AIDS, TB and so on</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SWOC Analysis for Migrant Populations in South Africa

**Strengths**
- Clear policy directives on providing care for migrants
- Evidence on what works
- Emerging good, field practices

**Weaknesses**
- Political leadership in ensuring and enforcing access
- Xenophobic attitudes within the health sector
- Denialism about migration and its impact on services/non-conducive environment
- Low socio-economic status leading to xenophobic attitudes within communities

**Opportunities**
- Migration issues are on the global development agenda
- Efforts from SADC secretariat to improve harmonisations of interventions
• Existence of international frameworks that advocate for migrants’ rights

Challenges
• Decrease of funding resources due to South Africa not being recognised as a developing country
XI. Addressing the Needs of Key Populations

Lessons from Global Best Practice

It is known that interventions aimed at preventing new HIV infections among key populations can impact on the broader epidemic, for example NSE among IDU reduces HIV transmission among their peers and partners. Similarly, focused interventions among SW can limit transmission between SW, their clients and their partners. Furthermore, the provision of comprehensive services and the use of antiretrovirals for prevention among MSM can limit new infections among them and their partners.

Legal and policy frameworks which uphold the human and public health rights of all people provide an enabling environment for increased access to interventions focused on key populations. More importantly, laws that outlaw same-sex behaviour, drug use and sex work have been shown to increase vulnerability to HIV and create barriers to accessing services, while also undermining basic human rights.

Effective strategies have been developed and implemented in different contexts across the globe to facilitate access to health services among key populations. Strategies which are based on human rights and public health approaches are more likely to have an impact in addressing HIV among key populations than approaches which are based on moralistic grounds. Legal environments which are non-discriminatory have been shown to significantly increase the proportion of HIV prevention services that reach key populations. In order to strengthen health care and legal systems to adequately provide for the needs of key populations, an effective mix of government and civil society service providers is essential.

Below are a selection of global environments or interventions which provide examples of how the creation of an enabling environment or focused interventions can empower key populations to realise their potential for health.

**MSM**

Recent WHO guidelines on the prevention and treatment of HIV and STIs among MSM and transgender people explicitly recommend interventions which (1) ensure the protection of human rights and the provision of services within inclusive environments, and (2) are provided in a non-discriminatory manner within health care settings.* Constitutional protection against discrimination based on sexual orientation and gender, as well as the removal of laws around same-sex behaviours in South Africa facilitated the establishment of MSM centres of excellence that have the potential to act as models for the roll-out of MSM services beyond major metropolitan centres.

**SW**

The decriminalisation of sex work in New Zealand has provided SW with employment rights, the ability to access government-sponsored medical services and increased protection against violence, coercion and unemployment. Since decriminalisation SW have reported improved working conditions, improved access to health services and there have been no known cases of HIV transmission from SW since the enactment of the law in 2008.

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* A list of recommendations for the prevention and treatment of HIV and STIs, as well as the level of evidence supporting these recommendations is provided as part of these guidelines.
IDU
Progressive drug policies implemented in Europe have provided evidence of effectiveness of the adoption of ‘harm reduction’ philosophies for IDU. Dutch policies for the integration of drug prevention, harm reduction and treatment programmes were introduced in the mid-70s, and in the late 80s were complemented by alternative drug law enforcement measures. In 2010 only 2% of known HIV infected people in the Netherlands were known to have been infected through drug use, and there has been a constant decline in new HIV infections between 1996 and 2010.\(^\text{235}\)
Policy reform in Portugal and Switzerland have had dramatic effects on controlling the spread of HIV and associated morbidity and mortality among IDU, and have not resulted in increased drug-use behaviour in either of these countries.\(^\text{236, 237}\)

Recommendations for South Africa
The recommendations generated from the key population gap analysis, and the revisions and prioritisation which occurred during provincial and national consultations are provided below.

Guiding principles
- Interventions and policy should employ human rights-based and public health-based approaches. At no time should the basic human and constitutional rights of individuals be undermined by legal frameworks and policies which do not facilitate enabling environments for the implementation of programmes focusing on key populations.
- All forms of discrimination, including that based on sexual orientation, gender and behaviours have a negative impact on the health of individuals. Service providers need to be sensitised to the vulnerabilities facing key populations and should be accountable for the provision of non-stigmatising, non-discriminatory services.
- ‘Harm reduction’ needs to be recognised as a philosophy, not a programme, which aims to maximise health and welfare of all.
- Focused interventions should reflect the heterogeneity of key populations and should address the factors which increase their vulnerability to HIV infection.
- Key populations may form part of one or many groups and this should be reflected in strategic planning and programme development and implementation.
- A mix of government and civil society organisations should be mandated to implement funded, focused interventions.
- The removal of punitive laws, legislation and policy that reduces access to comprehensive HIV prevention, treatment, care and support services is required in order for South Africa’s national HIV response to have an impact and to reach the goals of zero new infections, zero stigma and zero AIDS-related deaths.

General Recommendations
- Conduct population size and national HIV prevalence estimates for key populations, as well as characteristics of various populations and their specific risk behaviours.
- Ensure representation and active participation of key populations on SANAC and relevant provincial structures, and appropriate support structures for such representatives.
- Develop and implement targeted HIV testing, prevention, treatment and care programmes for key populations which are sustained, responsive and integrated into communities.
- A minimum package of services for all South Africans should include: VCT; active screening and treatment/referral for STIs and TB; access to condoms and lubrication; reproductive health services (family planning, termination of pregnancy services, PAP smears); male medical circumcision; appropriate vaccinations (HPV, hepatitis A, B); PEP and linkage to HIV; medical and mental health; substance abuse; and social and legal services. This should all be complemented for specific key population components.
- Mainstream government HIV messaging and HCT services should include risks associated with unprotected anal intercourse and drugs use, including injecting drug use.
• Government-employed health care, police and justice service providers should receive key population sensitisation training in order to reduce stigmatising attitudes and behaviours towards clients. Additional technical training should also occur as appropriate

• Formative and epidemiological data needs to be collected among women who have sex with women and transgender people to guide evidence-informed interventions targeting these groups

• Well-defined output and outcome indicators have to be formulated with workable sources of verification and time planning for monitoring, evaluation and accountability purposes – enough resources to be allocated to assure policies are credible and likely to be implemented

Recommendations for MSM

Prevention
• Development of nationwide HIV prevention messaging, specifically to target unprotected anal intercourse

• Biomedical prevention – increasing access to ART as prevention in PEP and PrEP and early treatment for those where risk is high, for example high-risk MSM and SW

• Integration of an MSM package within the general prevention package in an attempt to address stigma

Treatment, care and support
• Health care worker training for DoH health care providers (counsellors, nurses, doctors) – one-day basic sensitisation for broad range of facility staff, with additional one-day medical training for doctors and nurses – occurring in all provinces, with system of mentorship for ongoing support

• Continuation of established specialised MSM clinics in Cape Town and Gauteng, combined with a phased approach to provide direct services to other areas, with an initial focus on prevention (behavioural and biomedical) – establish in KwaZulu-Natal and the Eastern Cape initially, with the goal of establishing a centre in each province by the end of the new NSP period

Research, monitoring and surveillance
• Studies to understand specific subcultures of MSM

• Economic evaluations and operational research on interventions during the NSP period which also allow for improved UNGASS reporting

Advocacy, human rights and access to justice
• Share expertise with other African countries – potentially through health care worker training, linking and learning

• Increase representation of MSM on regional bodies for active participation in planning, development and evaluation of HIV and related interventions

Recommendations for IDU

General
• Improved integration of HIV/IDU services at state (and private) rehabilitation centres

• Provide funds for targeting prevention and treatment programmes for IDU through the development of provisions within the NSP

• Advocate for HIV prevention, treatment, rehabilitation and harm reduction programmes, which should be integrated into the programmatic response

• Capacity building and sensitisation for health care workers and law enforcement

• Use existing TWG in collaboration with the CDA to develop a harm reduction philosophy/policy for the South African context

Prevention, treatment, care and support
• Information, education and communication materials targeting drug use and HIV-prevention messaging should be provided in a gender-specific manner – specifically, there is a requirement for messaging aimed
at increasing awareness around HIV risks and drug use, including injecting drug use

**Development of a comprehensive ‘Harm Reduction’ Package**

- NSE programmes
- OST and other drug dependence treatments (detox and rehab)
- VCT
- Antiretroviral therapy (ART)
- Prevention and treatment of STIs
- Condom programmes for drug users and their partners
- Targeted education and communication (IEC) for IDU and their partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of TB

**Research monitoring and surveillance**

- Prevalence study of drug practices, of unsafe sex practices (under the influence of drugs), and of HIV among drug users, knowledge among drug users regarding safe drug use, safe sex, HIV, hepatitis (A, B and C), and prevention and treatment possibilities
- Fund the activities of the Drug Use and HIV TWG

**Advocacy, human rights and access to justice**

- Finalisation and implementation of the Prevention and Treatment of Substance Abuse Bill inclusive of defined harm reduction measures, NSE, OST and HIV prevention, treatment, care and support strategies targeting drug users, including IDU. Decriminalisation of drug possession for personal use (small quantities)
- Provide government subsidy for those NGOs and community-based organisations (CBOs) that address drug and HIV risks in a comprehensive and integrated manner
- The DoH to include the provision of methadone/opioid substitution therapy to treat drug-dependent people within the Medicines Control Act
- Develop strategic health care policies that address IDU co-morbidity factors such as HIV/AIDS and psychiatric illness

**Recommendations for SW**

**General**

- Remove all criminal laws around sex work and implement occupational health and safety laws that will protect SW and thus, public health.
- Involvement of SW within the drafting and implementation and roll-out of all programmes

**Prevention**

- Employ peer educators to provide condoms (particularly female condoms), lubrication, IEC materials and linkages to services for SW, their clients and their partners
- Engage pimps and hotel managers in interventions to encourage safe sex practices. Recognise the unexplored potential in terms of using pimps as agents of change. Roll-out programmes that target male clients

**Treatment, care and support**

- In addition to general public education and anti-stigma campaigns, targeted sensitisation training for key stakeholders including police, customs officials, journalists, judiciary, teachers etc. Particular attention should be paid to the SAPS and sensitivity and values clarification training should be rolled out to all police stations in SW ‘hotspots’
- In areas where sex work is prevalent, specialised SW clinics and mobile services should be implemented. In areas where SW numbers are low, sex work-friendly services should be integrated into existing services – sensitisation training needed for all health care workers.
XI. Addressing the Needs of Key Populations

Research, monitoring and surveillance
- Map areas in South Africa where sex work is highly prevalent
- Monitoring, evaluation and surveillance of new NSP targets
- Engage and involve SW in more comprehensive research and programme initiatives

Advocacy, human rights and access to justice
- Decriminalisation of sex work – SANAC through the NSP should be explicit that they recommend the decriminalisation of sex work as a public health strategy that protects human rights. They should encourage government to embark on law reform, including the development of an occupational legal framework to protect SW or ensure that existing protective labour and occupational health and safety laws apply to SW, and the removal of municipal by-laws relating to sex work (especially soliciting or importuning) should be repealed
- Include SW in decision-making processes
- Lobby international donor organisations to remove funding restrictions on health programmes that are based on ideology, for example the PEPFAR’s ‘Anti-prostitution Loyalty Oath’

Recommendations for Migrant Populations

General
- Capacity building of health care workers on migration and health/HIV, including migrants’ rights
- Harmonisation of treatment protocols across the borders: ARVs, TB treatment and minimum standards of care

Prevention
- Access to prevention services, tools and technologies
- Targeted peer-led social and BCC, which include the development of culturally sensitive IEC material
- Implementation of existing policy – disseminate, enforce and monitor
- Engage with migration, specifically migration-affected communities

Research, monitoring and surveillance
- Research to understand the social factors that increase vulnerability
- Mapping of migrant communities
- Strengthen health information systems to capture data on migrants, for example health passports
- Understanding the links between migration and other key populations (SW population)

Treatment, care and support
- Addressing barriers to access, including language and cultural barriers
- Capacity building of health care workers on migration and health/HIV including migrants’ rights

Advocacy
- Develop key advocacy messages that reflect and communicate the rights of migrants to accessing health services, the need for public health policy that incorporates migration health issues, and putting migration health onto the public health agenda
- Facilitate dialogue at policy and strategy level, and raise the profile of migration health through dissemination of key information (based on research) to inform appropriate policy development and programme implementation

Recommendations for Prison Populations

General
- Implementation of an aligned, comprehensive HIV package for the offender population
- Correctional (and law enforcement) facilities are microcosms of the larger community to which most inmates will eventually return

- Removal of municipal by-laws relating to sex work as a public health strategy that protects human rights. They should encourage government to embark on law reform, including the development of an occupational legal framework to protect SW or ensure that existing protective labour and occupational health and safety laws apply to SW, and the removal of municipal by-laws relating to sex work (especially soliciting or importuning) should be repealed
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Recommendations for Prison Populations

General
- Implementation of an aligned, comprehensive HIV package for the offender population
- Correctional (and law enforcement) facilities are microcosms of the larger community to which most inmates will eventually return
• Through a multi-sectoral approach, government agencies including the DDoH, the DCS and the SAPS must collaborate toward implementation of an aligned, comprehensive HIV package for the offender population.

Prevention
• Develop and implement an anti-gang strategy that addresses the reduction of sexual violence
• Implementation of diversion programmes for youth offenders and offenders of relatively small crimes
• The DCS and the SAPS must develop and implement a comprehensive policy framework addressing sexual violence against persons in custody.

Treatment, care and support
• Strengthen management information systems with an eye toward improving treatment and care for HIV-positive inmates
• Address overcrowding, privacy and confidentiality, and infection control (including through the consistent provision of appropriate condoms and lubricant in detention facilities)
• Ensure appropriate care for inmates who are raped: victims must be taken to the local hospital to receive medical care, a forensic examination, testing for HIV and other STIs, PEP related counselling and timely follow-up. These services must be carried out at no cost to the victim and only with the victim’s informed consent
• Strengthen complaint systems available to inmates and improve access to health services
• Link health services in the correctional services system to health services in society to ensure follow-up treatment and care when people enter or leave prison

Educational efforts for officials and detainees
• Training of correctional officials in managing HIV in detention settings, including by providing training on the basics of HIV and its transmission
• Sexual health and safer sex practices, including awareness of HIV and other STIs
• The application of the Sexual Offences Act in detention settings, including the gender-neutral statutory offence of rape, the establishment of other crimes pertinent in detention settings and the right to receive counselling and PEP in cases of possible exposure to HIV as a result of a sexual offence

Research, monitoring and surveillance
• Strengthen public/private partnerships for health services provision
• Strengthen monitoring and evaluation systems for measuring impact/outcomes and planning – use of validated tools, for example addiction severity index of WHO substance abuse tools
• Ensure that DCS and those monitoring other places of detention are properly recording reports of sexual abuse

Advocacy
• Policy developers, correctional officials and law enforcement must be sensitised on issues pertaining to diverse key populations in detention
• Ensure training and IEC material is available in all languages, including foreign languages
• Training of correctional officials in HIV management

Recommendations for Transgender People

Prevention, treatment care and support
• Provision of a minimum service package for key populations which is tailored to the specific needs of transgender people

Research, monitoring and surveillance
• Sentinel HIV surveillance and behavioural surveys to build an evidence base around HIV epidemiology among transgender people
Advocacy

- Representation in relevant forums in order to actively participate in the development of interventions focusing on transgender people
XI. Dissemination

The findings of the literature review were developed into an abstract, which was accepted for presentation at the 2011 International AIDS Society Conference in Rome, July 2011. The outcomes of the stakeholder feedback were drafted into an abstract which was submitted for presentation at the SA AIDS Conference in Durban from 7–10 June 2011, but was not accepted for inclusion in the conference programme. The outcome of the stakeholder consultations have been summarised into an abstract that was accepted for presentation at the ICASA conference in Addis Ababa, December 2011.

This key population report will be disseminated in hard and soft copy format to all stakeholders, and more broadly to advocate for additional programming focused on key populations. The document will be used to provide insight and background to key populations and provide support for increased focus on key populations in the NSP (2012–2016). A key population policy brief will also be developed and distributed to partners as an advocacy tool.

The findings of this process will also be submitted for publication in a peer review journal.
In conclusion, the findings from these consultations give evidence of the need for improved coordination of all stakeholders, with the crucial participation of affected communities and populations in all stages of programmatic development. All HIV interventions must be underlined by rights-based and public health-based approaches.

Commitment to the NSP is vital, as is increased accountability, with ongoing review and improvement throughout. Advocacy for the needs of key affected populations needs to continue, and must be informed by ongoing research.

The key population gap analysis process has developed a network of individuals and organisations which have the potential to be mobilised to advocate for further support of key populations within the national HIV response.

The consultation process has also built the capacity of the researchers and implementing partners to assimilate a wealth of information from a variety of sources and to collaborate with partners to achieve a common path to improve the national HIV response.

It is hoped that the gaps, as well as strengths, identified will be used to more effectively guide future research, policy and programmes focusing on key populations in South Africa.


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Key Populations, Key Solutions


Men who have sex with men (MSM), transgender people, sex workers (SW), injecting drug users (IDU), prison populations and specific migrant groups are disproportionately affected by HIV and in many circumstances are marginalized by society. This document provides an overview of the situation pertaining to these key populations and provides prioritized recommendations for consideration for the next South African National Strategic Plan on HIV/AIDS, TB and STIs (NSP) (2012-2016).

A thorough data collection and consultation process was undertaken from November 2010 to July 2011. An extensive network of representatives from research, governmental, civil society and other sectors were engaged during all stages of this project. Provincial and national consultations were undertaken in order to provide an opportunity for review of findings of the consolidated process and to obtain consensus on the recommendations to be forwarded to the SANAC secretariat for consideration for inclusion in the NSP. 2012-2016.