PITCH

Accelerating community-led HIV responses: adapting positive practice beyond the COVID-19 crisis

PITCH Partnership to Inspire, Transform and Connect the HIV response

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"I was young, I liked to socialise, and I started using drugs. I've suffered, I've spent time in prison, and I've lost everything. The discrimination hurts. I am a chronic patient, not a criminal. Please don't leave me behind." Myanmar.

6. Intersections across marginalised populations

Challenges for intersections across marginalised populations during COVID-19

Intersectionality means understanding that human beings are shaped by the interaction of multiple different social locations or positions, such as race, gender, sexual orientation, gender identity and expression, class, geography, age, dis/ability, migration status, indigenous status and religion. These interactions occur within connected systems and structures of power. Intersecting identities, experiences and barriers combine and compound social exclusion in ways that go beyond a single aspect of identity, and this in turn increases negative health outcomes, including for HIV and COVID-19. Indeed, the pandemic has highlighted the impact of global inequalities along multiple dimensions.

As each chapter on individual marginalised populations has shown, the impacts of COVID-19 on marginalised groups have frequently been severe and have heightened existing inequalities. While there were common challenges across all six groups in this study, the impacts for some people were increased by pre-existing conditions that complicated their health and well-being and worsened their already precarious position. Agency and freedom, personal boundaries and bodily integrity are progressively eroded with every marginalisation. Some inter-generational

impacts of this marginalisation are inherited, others a result of life experiences or precariousness resulting from poverty or inequality.

The tendency to see key populations as homogenous and with a single story, ignores the complexity of needs and experiences that directly impact on individual agency. Some marginalised people are more criminalised than others. According to the UNAIDS Global Update[1], 69 countries criminalise men who have sex with men in their diversity, while 19 of the 134 countries included in reporting, criminalised transgender people. This data ignores the disproportionate risk that transgender people, and transgender women in particular face from the enforcement of anti-homosexuality laws. Since transgender people's gender identity is ignored, and many transgender women are highly visible, they are targeted both by laws against homosexuality and those that criminalise transgender identities. It also makes invisible the disproportionate impact of many other laws on specific populations.

These laws, and others – including punitive drug laws and petty offence laws such as vagrancy, loitering, begging, touting or failure to pay debts – result in people of colour, those living in poverty, transgender people, people who use drugs and people who sell sex being disproportionally represented among people incarcerated in almost all countries.

States of Emergency and Disaster regulations imposed in response to COVID-19 have added to the existing burden of criminalisation – because key populations and those affected by poverty and other forms of intersectional marginalisation were less able to comply with stay-at-home and social distancing orders, and faced arrest and the threat of criminal records if they were unable to do so.

An increased rate of incarceration and of violence also has implications for people's ability to get and remain employed, as well as to access basic needs such as housing. Moreover, incarceration itself poses a significant threat to health as many languish in congested prisons with inadequate health and sanitation and face the increased risk of COVID-19 as well as other diseases like tuberculosis (TB).

The extent to which marginalised populations' living conditions were affected by the COVID-19 pandemic also clearly demonstrated the intersectionality of marginalisation. For example, while all lesbian, gay, bisexual, transgender and queer (LGBTQ) people are more likely to experience insecure housing compared to the general population, transgender people are the most likely to be affected. In the USA, 42% of transgender people have experienced homelessness in their lives, compared with the 30% average for all LGBTQ people[2], and 40% of transgender people had experienced some form of housing discrimination or instability, including eviction or being denied a home or apartment because they are transgender[3]. These effects were compounded when transgender people were black.

In addition, homeless transgender people are also less likely to be accommodated in homeless shelters, because single-sex shelters often insist on allocating transgender people to spaces on the basis of their birth sex as opposed to their gender identity.

In Thailand, transgender women who sell sex, and who use drugs, face compounded discrimination, violence, imprisonment and oppression, especially from law enforcement, due to their multiple marginalised identities. During the pandemic, they have been unable to work in the sex industry due to the closure of the entertainment industry, but they were also unable to access social protections as many lacked the necessary identity documentation. Added to this, outreach by sex worker organisations was halted due to lock downs and restrictions on movement.

For many transgender sex workers, being locked down or moving back to live with families or intimate partners, compounded with the frustrations of a lack of income, exacerbated

rates of sexual and gender-based violence (SGBV). Under normal circumstances, sex workers experience high rates of intimate partner violence[4], just as LGBTQ people face increases in violence after prolonged exposure in homo- and transphobic environments. Lockdown has worsened this, leading to mental health challenges. A survey by an LGBTQ organisation in Lebanon showed that 62% of community members needed mental health support.

In South Africa, homeless transgender sex workers, many of whom also use drugs and are living with HIV and TB, were unable to earn an income. They were removed from the streets and relocated to a quarantine camp, where transgender women reported being bullied and assaulted by men. The South African Human Rights Commission later ordered the camp to be shut down because it was congested, unhygienic, and had violated multiple human rights[5]. The camp provided little to no harm reduction services to residents many of whom were ill from the effects of drug withdrawal. Those who stayed on the streets experienced deteriorating conditions and increased visibility to law enforcement. At least two of the women died during this time, due to diarrhoea which exacerbated their existing health conditions[6]. Another, Robyn Montsumi, a black lesbian transgender sex worker activist was arrested for drug possession and died under suspicious circumstances in police cells days after her arrest[7].

Positive approaches adopted during the COVID 19 pandemic

Recognising the diversity of needs and responding to those most in need

Communities of marginalised people have demonstrated their solidarity with each other during the COVID-19 crisis. Support for those most affected by the economic crisis and loss of livelihoods emerged within the community from the local to global level. For example, members of communities opened their homes to others who had nowhere to stay, and volunteered their time collecting donations and distributing food parcels

Care support packages with condoms and information are given to the LGBT community in Hanoi, Vietnam.

to those most in need. Community-based and -led organisations were the first responders, mobilising to meet the emergency needs of community members. And members of marginalised populations in higher income countries donated generously to crowdfunding campaigns launched by organisations in lower- and middle-income countries.

For example, Sex Workers Education and Advocacy Taskforce (SWEAT) and Sisonke sex workers movement in South Africa launched a crowdfunding campaign to support sex workers who lost their livelihoods and supported their dependent children: acknowledging that women who sell sex are breadwinners and mothers. The funding supported 704 adults and 939 children from April to October 2020[8].

Mother's for the Future, a project hosted by SWEAT, specifically embraces sex worker mothers and offers peer support for them, as well as pregnant and new mothers. The project recognises that sex workers with dependents face additional pressures to make money and may take additional risks to do so. It also recognises that women of colour living in poverty and who sell sex have increased risk of pregnancy-related complications and struggle to access quality SRH services. During COVID-19, the project also offered assistance to mothers who faced additional childcare responsibilities and who could not work due to lockdown measures.

Cross-cutting interventions

Responsive, flexible, local solutions, developed by and with people with multiple marginalised identities can address the complexity of people's lived experiences. For example, the Kenyan Network of People Who Use Drugs (KeNPUD) and VOCAL Kenya have collaborated to equip people who use drugs to respond to rising violence against their peers in Nairobi during the pandemic. Trained in counselling, mediation and conflict resolution, as well as directly linked with communities of people who use drugs, they can act as first responders in cases of violence and refer to health and legal services[9]. Meanwhile in Pattaya, Thailand, a community of transgender sex workers who use drugs have built a network of support systems amid COVID-19, from community-led dissemination of food and hygiene packages to a harm reduction gathering[10].

Uniting to amplify and address common needs and challenges

The building of alliances and solidarity across communities and movements during the HIV response has taken time and effort, yet it has paid off during the pandemic.

As an example of solidarity amongst key populations, global networks issued joint key population statement on World AIDS Day 2020, highlighting the parallels between HIV and COVID-19, both in terms of the vulnerability key populations face, but also in terms of the power, reach and value of strong, community-led networks[11]. And in a welcome move, UNAIDS announced on Human Rights Day, 10 December 2020, the launch of a Solidarity Fund to support social entrepreneurs and small-scale businesses owned by people living with HIV, women or members of marginalised communities, acknowledging the particular precariousness faced by these groups during COVID-19.

Frontline AIDS, as an organisation working closely with communities of marginalised people, acknowledges that COVID-19 has placed increased pressure on community-based services. It expanded its support via the Rapid Response Fund (RRF) to a wider number of communities through its grant mechanism, and partnered with regional networks of marginalised populations to ensure funding was well placed. From April to July 2020, using reallocated unrestricted funds, the RRF issued 88 grants to support LGBTQ people, sex workers, people who use drugs and people living with HIV. The Fund also issued seven additional COVID-19 grants from other funding sources, including one grant targeting people who use drugs, and another for sex workers.

Advocacy to reduce marginalisation and exclusion

Adopting an intersectional approach means calling attention to immediate needs, while at the same time recognising and addressing the structures and systems which perpetuate and entrench inequity, oppression and exclusion – including along lines of racial and ethnic identities. Structural barriers impact on all aspects of the health and wellbeing of marginalised people.

In 2020, The African Court for Human and People's Rights heard a petition brought by the Campaign on the Decriminalisation of Petty Offences in Africa. In December 2020, the Court ruled that archaic vagrancy and petty offense laws, which are often relics from the colonial era, are not compatible with the African Charter on Human and Peoples' Rights, the African Charter on the Rights and Welfare of the Child and the Maputo Protocol on the Rights of Women. The Court found that these laws disproportionately target people who are poor and homeless, and that many African countries abuse vagrancy laws to arrest and detain people even when there is no proof of criminal conduct. The Court instructed member states to repeal and reform these laws.

PITCH partner, the AIDS and Rights Alliance for Southern Africa (ARASA), engaged with many marginalised population groups across the region, to mobilise them around advocacy to address structural barriers to HIV prevention[12]. Organisations representing sex workers, people who use drugs, and LGBTQ people came together to agree a regional plan. This action continued in 2020, supporting country efforts in Zimbabwe and Mozambique, which included engaging with the Southern African Development Community (SADC) with UNAIDS support.

As humans, we have the right to life and to carry out our daily activities without discrimination. Mainstream HIV programming considers us as data. How many tested? How many reached? How many positive? When we are reduced to statics, our emotional needs and mental wellbeing is forgotten. We are humans, not numbers.

Case study

Addressing intersecting needs and vulnerabilities of male sex workers via community-led responses in Kenya

HOYMAS is a male sex worker-led organisation, in Nairobi, Kenya. This case study describes how they were affected by the COVID-19 pandemic and restrictions, how they adapted to meet their clients' changing needs, and some of the barriers they faced in doing so. The case study consists of excerpts from 'Sexual health among Kenyan male sex workers in a time of COVID-19' by Macharia et al[13].

HOYMAS has a network of specialised clinics run by and for men who have sex with men. It has created safe spaces where male sex workers, who are doubly stigmatised, can take control of their sexual health.

Specialist services are needed to meet the health needs of gay men and men who have sex with men.

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When the government announced Nairobi's lockdown in March 2020, HOYMAS peer educators quickly adapted their roles towards sensitising sex workers to the threat of COVID-19. Face-to-face meetings were halted but peer education was moved onto virtual channels, including WhatsApp groups, Facebook and other online forums. These platforms gave members the chance to discuss the situation and ask questions.

However, given the financial problems facing men who sell sex during the pandemic, challenges quickly emerged. Since many HOYMAS members own 'pay-as-you-go' cell phones, they were unable to afford or access these platforms, and unable to download the information and education materials developed by the outreach team.

Recognising the psychosocial needs of their members also, HOYMAS initially set up support groups at the drop-in centre. These were limited to six people and had a two-metre distancing rule. However, attendance dropped when matatu (local transport) costs doubled after the government placed restrictions on the number of passengers they were allowed to carry.

Prior to COVID-19, HOYMAS was providing regular testing, counselling and treatment for sexually-transmitted infections (STIs) and HIV for over 5,000 members. But over recent years, they had struggled to have their clinic officially recognised by the county government. This prevented them from recruiting more clinical staff, and in the pandemic context, prevented them from accessing personal protective equipment.

HOYMAS' crisis centre, staffed by trained paralegal workers, has shut due to COVID-19 and its mandatory curfews. This has left people with severe mental health problems without services, and since community paralegals are not categorised as 'essential' health workers, they are banned from going out at night to respond to incidents of violence.

All these challenges, amidst dwindling resources, underscore the vital role of organisations like HOYMAS, trying to meet the health needs of 5,000 highly stigmatised men who remain largely excluded from the public health system, and face the double stigmatisation of being men who have sex with men and sex workers. The delivery of vital, life-saving services is at risk of collapse. Support for community-led organisations, like HOYMAS, is essential as they are the key way to deliver effective responses to the most marginalised populations, who are at the greatest risk of COVID-19.

Recommendations

Engage community-based and community-led organisations in crisis responses

COVID-19 has shown that community-based and community-led organisations serving marginalised people are best placed to address intersectionality, and the often-complex needs of individuals. In addition, COVID-19 response mechanisms which are responsive to and inclusive of diverse voices and experiences are more likely to be appropriate, acceptable and effective.

Community-based and -led organisations should assertively claim their space in decision-making platforms to ensure communities historically and presently most impacted by exclusion are included, resourced and their needs accounted for. This needs to move beyond inclusion to approaches that shift power, including along lines of race, to support movements and activists to advocate beyond consultative platforms, for transformative policy, legislation and systemic change. It also may mean providing training for the most marginalised to be able to meaningfully engage and participate, focusing on equity not equality. Mainstream health and HIV service providers must learn from, politically support, and fund community-led responses to address intersectionality.

Improve policy and legislation to protect the rights of marginalised groups

Civil society and community led organisations should collaborate in their efforts to advocate for the decriminalisation of sex work, homosexuality, cross-dressing, drug use and possession, HIV transmission, and laws which punish adolescent girls and young women for sexual behaviour or pregnancy, or restrict their access to SRH services. Using an intersectional lens, they should also consider other laws, policies and practices that disproportionally target marginalised communities by compounding social exclusion and progressively eroding people's resilience and re-integration. These include petty offense laws and regulations, as well as local authority by-laws.

Legal protections against violence, abuse, and discrimination are seldom used by marginalised people. Thus, active measures must be taken by law enforcement agencies to help them access these protections. Additional protective measures can be put in place in the form of standard operating procedures to protect the most marginalised from violence and other human rights violations, and to enable them to access services. States are increasingly recognising the negative impact of punitive laws and policies, including the economic cost of these laws. Reviewing such approaches, and adopting evidence informed legal frameworks and policies to achieve the most beneficial health outcomes must be considered.

Focus social protection and economic recovery plans on those most at risk

An approach which is not intersectional often renders forms of marginalisation invisible, and gives the illusion of homogeneity. Methods of gathering data on who is most vulnerable need to be more sophisticated and disaggregated to provide a clearer picture of the impact of intersectional marginalisation. With more robust data, decision-making around social protections can be better targeted to those most in need. In recovering from the impact of COVID-19, humanitarian responses, social protection schemes and plans for economic recovery should cover the needs of marginalised populations.

Harness digital opportunities, and bridge the digital divide

COVID-19 has been an accelerator of digital innovations, but for many people digital platforms are not affordable, accessible or trustworthy. Moreover, the rapid growth of digital health interventions has not always been coordinated or well considered.

Civil society and community organisations should embrace digital innovations in their own work and continue to build their own skills, infrastructure, vigilance and policy frameworks in this area. They

must also demand that implementers of digital solutions engage communities in planning, design, implementation and evaluation of the application of digital tools in the COVID-19 and HIV response. In addition, they should continue to call attention to the digital divide, reminding donors and governments that the most marginalised people are least likely to have access to the internet, which has the potential to marginalise them further. Finally, they should request donors to support capacity strengthening of community advocates to navigate digital advocacy spaces and further strengthen their activism in the digital health space.

Connect with social justice initiatives

Community-based and -led organisations are increasingly joining global struggles to transform structures and power imbalances that entrench and reproduce inequalities. These efforts must be sustained, and lessons drawn from these struggles can be integrated into HIV, TB and other health challenges. For instance, in addition to sensitising and training police, it is also vital to transform policing practices to address bias and abuse of power, and call for greater accountability in the broader criminal justice system. Without engaging in a transformational agenda individual experiences of injustice will continue to be repeated generation after generation.

Endnotes

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