THE SECOND HIGH LEVEL CONSULTATION MEETING ON HIV IN CONSERVATIVE SETTINGS

PROMOTING A MORE INCLUSIVE APPROACH TO HIV: INCLUSION AND SUPPORT

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INTRODUCTION

The Second High Level Consultation on HIV in Conservative Social Settings, Promoting A More Inclusive Approach to HIV: Inclusion and Support, was held 30 - 31 January 2016 in Istanbul, Turkey. The Global Institute for Health and Human Rights (GIHHR) and the International AIDS Society (IAS) organized the consultation with support from the OPEC Fund for International Development (OFID) and the Turkish Ministry of Health.

The consultation brought together governmental officials, healthcare professionals, scholars, religious leaders, and civil society representatives from 15 Islamic majority countries including Afghanistan, Egypt, Iran, Jordan, Kyrgyzstan, Lebanon, Malaysia, Morocco, Oman, Pakistan, Saudi Arabia, Syria, Tajikistan, Tunisia, and Turkey; in addition to representatives of IAS and GIHHR.

THE CONSULTATION’S OBJECTIVES WERE:

1) To discuss how to improve the availability, accessibility, acceptability and quality of HIV prevention, treatment, care and social support

2) To discuss how to fund and strengthen policies and programs to deliver comprehensive national and regional responses to HIV

3) To discuss how to promote legislation that respects, protects, and fulfils the rights of people living with HIV (PLHIV) and associated key populations, including people who inject drugs, men who have sex with men, sex workers and transgender people

4) To improve regional and international research and data exchange

5) To strengthen dialogue among key stakeholders, including religious leaders, policymakers and opinion leaders

6) To inspire key stakeholders, including religious leaders, policymakers and opinion leaders to increase support for PLHIV and to decrease HIV-related stigma and discrimination

7) To emphasize the importance of addressing the broader health issues of women and girls and key populations (people who inject drugs, men who have sex with men, sex workers and transgender people)
BACKGROUND

In 2013 the IAS, International HIV Partnerships and the Dana-Farber Cancer Centre at Harvard Medical School organized a preconference symposium prior to the 7th IAS Conference on HIV Pathogenesis, Treatment and Prevention (IAS 2013) in Kuala Lumpur, Malaysia. HIV/AIDS in Islamic Majority Settings brought together 50 researchers, scientists, policymakers, program implementers and community representatives from 15 Islamic majority countries. The meeting reviewed national HIV responses in these settings and the implications for key populations.

In April 2014, IAS and OFID hosted the First High Level Consultation on HIV, titled Overcoming HIV in Conservative Social Settings. The two-day meeting brought together 30 religious leaders, scientists, civil society actors, people living with HIV, and representatives of United Nations organizations, most of whom came from OPEC member countries and other conservative social settings. Following two days of discussions and presentations, the group identified a range of recommendations for ways to better respond to the HIV epidemic in conservative social settings. In July 2014 the recommendations were presented as a Call to Action at the 20th International AIDS Conference (AIDS 2014) in Melbourne, Australia.

The Second High Level Consultation aimed to build on the outcomes of the two previous meetings. The consultation focused on the effect of HIV among key populations (people who inject drugs, men who have sex with men, sex workers and transgender people) including cultural, social, and religious experiences of PLHIV in conservative social settings. The Consultation included presentations by delegates followed by group work and plenary sessions. A summary of key discussion topics and recommendations from the consultation are outlined below. The list of meeting participants is provided in the appendix to this report.

To advance this important dialogue, the work and recommendations generated at the consultation will be presented at a satellite session during the 21st International AIDS Conference (AIDS 2016), to be held July 18 - 22, 2016 in Durban, South Africa. A working group will be launched at AIDS 2016 to allow participants from the Middle East, North Africa and South East Asia to continue sharing their knowledge of effective HIV advocacy strategies, and to complement current HIV programs and advocacy in the region.
PART I: KEY POPULATIONS IN
SOCIALLY CONSERVATIVE SETTINGS

The HIV epidemic in conservative settings disproportionately affects people who inject drugs, men who have sex with men, sex workers and transgender people. Sharing needles and unprotected sex are some of the key drivers of the HIV epidemic.

Throughout the MENA region the HIV epidemic is most acute among people who inject drugs. Internal and external migration and displacement add to the severity of the problem. Only 11% of HIV-positive people who inject drugs in the MENA region have access to treatment. While harm reduction programs have been implemented in some countries, including Afghanistan and Iran, social, religious and cultural barriers persist that prevent many people who inject drugs from accessing adequate HIV prevention, testing and treatment services.

Stigma against key populations is prevalent in socially conservative settings, with media fueling negative perceptions of people who inject drugs, men who have sex with men, sex workers and transgender people. Providing media outlets with more accurate information could contribute towards reducing stigma and increasing awareness of HIV and AIDS.

In addition, although not limited to the MENA and South East Asia regions, punitive laws and practices deter people who inject drugs, men who have sex with men, sex workers and transgender people from seeking the health services they need. Injection drug use is not legal in Afghanistan, Egypt, Iran, Jordan, Kyrgyzstan, Lebanon, Malaysia, Morocco, Oman, Pakistan, Saudi Arabia, Syria, Tajikistan, Tunisia, and Turkey, but some countries do have policies that work to support people who inject drugs. For example, Iran and Malaysia have extensive harm reduction programs that provide clean needle exchange services to help reduce HIV transmission. Most participants reported that homosexuality is criminalized in their home countries, except for Turkey. However, criminalization does differ, with some countries instating sodomy laws, imprisonment for homosexuality and even public punishment. These policies fuel persecution and make HIV disclosure extremely difficult.

Further, reliable data on HIV incidence and prevalence among key populations is limited or absent in many conservative social settings. Inconsistent data collection is a key challenge to understanding the needs of key populations. In many instances, key populations are hidden populations that generally avoid accessing testing or treatment due to stigmatization and criminalization. Inadequate data makes it difficult to work with and comprehensively address the needs of key populations.

RECOMMENDATIONS:

• NGOs and civil society should work with media outlets to ensure accurate reporting, raise awareness of issues affecting key populations and to reduce stigma and discrimination

• Civil society and government agencies should ensure people who inject drugs, men who have sex with men, sex workers and transgender people are engaged in decision making for effective HIV policy and programs

• Health agencies and academia must create standardized, anonymous data collection programs for key populations to better track HIV incidence, prevalence and risk behaviours of key populations
Overall HIV prevalence is low in many socially conservative settings. As a result, some countries in the MENA region do not consider HIV a priority. However, the number of new HIV infections within the region is rising. The general lack of political support for HIV programs and HIV-related stigma has resulted in limited funding for interventions and studies aimed at understanding and preventing HIV in this region. The challenge of mounting effective national responses to HIV are further compromised by current laws and policy approaches that provide inadequate protections for PLHIV, particularly key populations. Legal protections for key populations are essential to delivering effective HIV services.

Community mobilization is vital to establishing a positive dialogue on HIV, finding allies, and creating a consistent and accurate messages throughout the community regarding HIV transmission and its prevention among key populations. Creating community-based strategies are critical to understanding the modes of HIV transmission and improving access to prevention and treatment within each setting. Additionally, community based programs should address the needs of recent migrants and unregistered citizens in many of these regions. Complicated immigration laws and issues around language and social exclusion are key challenges for migrants to access adequate health care services.

It is essential to increase NGO support for developing and implementing HIV programs in socially conservative settings. NGO support can stimulate greater funding for small-scale HIV projects that can then be delivered to the government as successful models. One participant noted, “The communication of prevention policies to society is also a challenge. Little context is provided to show a policy’s value as part of a bigger package of improved health services. Communication between science, academia and the community needs to be improved.”

Although successful HIV prevention strategies exist in socially conservative settings, harm reduction policies and programs tend to be either absent or inadequate to meet the needs of key populations. In some countries for example, harm reduction programs, like needle and syringe exchange programs for people who inject drugs are illegal. Further, comprehensive HIV responses are hindered by a lack of coordination between government agencies and non-governmental actors. Without broad support and a stable policy base, support for HIV programs for key populations tends to be highly dependent on individual leaders. As a result, support for HIV programs can quickly wane with changes in political and administrative leadership. The example of Iran shows that small, local programs and pilot projects can be used to demonstrate the credibility and effectiveness of harm reduction programs and help ensure their acceptance and adoption in national HIV programs.

RECOMMENDATIONS:

• NGOs, government and academic institutions should share successful programs with key stakeholders in socially conservative settings that can assist in scaling up prevention programming in similar locations

• NGOs should work with key populations within communities and create safe spaces for dialogue that then allows for community based HIV prevention programming

• NGOs should run workshops with government leaders, health care organizations, and community organizations to discuss positive prevention activities and lessen the burden of stigma amongst key populations

• Governments must work with civil society to ensure their legal and policy frameworks protect key populations, including the rights of people living with HIV
PART III: KEY POPULATIONS & ACCEPTABLE CARE

Meeting participants spoke of negative social attitudes towards key populations and how this, combined with limited prevention services, contributes to increased HIV transmission rates. There seems to be a perceived inability to separate religious beliefs from the delivery of prevention, treatment and care services. People ask “What have you done to get HIV?” rather than, “How can we best provide treatment and care?” Countries should standardize HIV treatment by providing treatment access to everyone, regardless of how and where they were infected. Against the background of stigma and criminalization, the lack of privacy and anonymity at healthcare centres further deters people who inject drugs, men who have sex with men, sex workers and transgender people from seeking healthcare services. The provision of effective healthcare services requires enforcing non-discrimination policies in healthcare settings, adequately training healthcare professionals to avoid discriminatory behavior, and counseling that emphasizes education and empowerment. Shifting services out of government health systems, e.g. through community-based testing and home testing, could further contribute to better service uptake.

Collaboration among NGOs and other civil society actors is needed to create innovative programs that integrate service options for key populations that are sensitive to local culture and traditions. Community mobilization with the assistance of NGOs could include the creation of mobile centres and teams that work in the field and to access hard to reach key populations for testing and treatment. Mobile centres can provide voluntary counseling and testing that allows for greater anonymity among key populations. Early diagnosis and treatment not only halts disease progression, but also significantly reduces the risk of HIV transmission. Treatment options should include counselling and support services to assist key populations in improving their overall health and wellbeing. HIV programs should integrate a number of prevention interventions, such as early diagnostic testing and counseling, pre-exposure prophylaxis (PrEP), needle and syringe exchange programs (NSP), and free condoms to reduce HIV transmission.

RECOMMENDATIONS:

- HIV care centers should train their healthcare workers to deliver non-discriminatory, culturally sensitive services
- Care centres should develop and implement training programs for healthcare professionals with the support of NGOs, government and academic institutions that promote inclusive, evidence-based and non-discriminatory work practices
- Care centres should create protocols that address testing, treatment, counseling and prevention for HIV-positive patients and key populations
- Care centres should encourage applications to NGOs and government agencies for grant-based seed funding to implement community-based care programs that can be incorporated into national HIV programs and services
PART IV: THE ROLE OF RELIGIOUS LEADERS IN THE HIV RESPONSE

Religious teachings have a strong influence on the HIV response and can potentially help people living with HIV. There was a general consensus among consultation participants that communities may have confused religion and tradition — essentially intertwining the two and allowing for traditional practices and beliefs to misinterpret what Islam does and does not allow. In some regions HIV is viewed as a punishment for sin, which has led to the widespread stigmatization of people living with HIV.

Participants agreed that comprehensive, accurate knowledge of HIV among religious leaders would strengthen the overall HIV response. Past efforts to build knowledge about community health issues among religious leaders have proven to be successful.

It is essential to engage religious leaders who are champions of people living with HIV. Religious dialogue regarding care for PLHIV and the right to live a stigma-free existence is another influential focus that should be included in religious doctrines. Islam does recommend supporting people in need of care. A Muslim jurist who participated in the consultation stated, “It is important that religious leaders do not let concepts of superiority and inferiority to occur between those who are not at risk and at risk. The role of religious leaders is to change this mentality, to not treat one another in inferior ways.”

Partnerships between religious leaders, scientists, academics and political leaders can assist in bringing consistent, contemporary messages to communities. Supportive messaging from both mosques and the government would be influential in addressing issues of stigma and discrimination. Such messaging should include collaborative programming between health ministers and leaders of religious affairs.

RECOMMENDATIONS:

• Religious leaders should promote understanding for people in need of care and support, including people living with HIV
• In preparing and delivering sermons, religious leaders need to distinguish core Islamic values from traditional beliefs that foster stigma and discrimination
• Religious leaders need to work in partnership with scientists, government leaders and civil society to effectively share key messages and communications on HIV
• Academia must be more active in engaging religious leaders in education and training programs to enhance support for people living with HIV
The Second High Level Consultation Meeting on HIV generated a rich discussion of ideas and action items to fight the HIV epidemic. Recommendations suggested by participants have the potential to become a key force in strengthening the response to HIV throughout the MENA and South East Asia regions. Increased communication and collaboration will enhance efforts to limit HIV transmission. Shared responses and actions will provide greater understanding of the complex issues and constituencies involved in the response to HIV.

The consultation provided a platform for participants from socially conservative settings to share challenges and discuss opportunities for collective growth and change. Involving leaders in healthcare, religion, government, non-government and other influential sectors is vital to halting the HIV epidemic. It is imperative to not only reduce HIV transmission, but to assist those living with HIV improve their wellbeing in an accepting society. The consultation demonstrated that HIV advocates must continue to address issues of stigma, find innovative ways to mobilize key resources and allies, and adjust attitudes and behaviors towards HIV in conservative social settings.

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