BRIEFING DOCUMENT

The Public Health Impact of Anti-LGBT Laws in Africa

OVERVIEW

Currently, homosexuality is criminalized in almost 70 percent of African countries, though not all of these laws are enforced (Amnesty International UK, 2014, Ottosson, 2007). In five countries, men who have sex with men (MSM) risk the death penalty if they are caught engaging in same-sex relations (Amnesty International UK, 2014; Downie, 2014, Ottosson, 2007). Recent measures have increased penalties against same-sex behavior in Uganda and Nigeria, and other countries in Africa are considering similar legislation (Raghavan, 2014; Debusmann, 2014).

In a region where more than two-thirds of all new HIV infections occur, these laws contravene public health and human rights (UNAIDS, 2013; Kates, 2014; Population Council, 2013). They endanger individual safety and restrict MSM, a population already at high risk for HIV, from accessing lifesaving HIV prevention and treatment services.

Punitive laws force MSM—and often their service providers—underground. Experience has shown that when states enforce such laws, men at high risk for HIV will stop seeking prevention and treatment services for fear of exposing themselves to prosecution. Providers may stop offering care or shift their strategies, making services more difficult to access. Among providers who continue to offer health services, many report that the laws make it more difficult to identify MSM in order to provide them with optimal care (Ahonsi et al., 2014; Downie, 2014; Kates, 2014; Population Council, 2013; Poteat et al., 2011, UNAIDS, 2013; see also Population Council case study in Nigeria).

Enough is known about HIV and the care-seeking behavior of MSM to expect the following potential negative health consequences to emerge from these laws:

- An increase in HIV incidence as MSM stop seeking care and lose access to HIV testing, prevention information, and safer sex supplies like condoms and lubricant, which may have reduced their risk.
- More cases of untreated STIs, which are known to facilitate transmission of HIV.
- Increased risk of drug-resistant virus spread, and higher viral loads with higher potential for transmission, as many people living with HIV and AIDS will find it more difficult to obtain antiretroviral treatment and adhere to treatment regimens.
- Decreased social connections and social capital among MSM, isolating them from support networks and services.

Driving at-risk populations and their health care providers underground undermines national and global commitments to achieving an AIDS-free future. In their 2013 Global Report, UNAIDS (2013, p. 7) affirmed that HIV-related stigma and discrimination—including institutionalized discrimination against key populations—"constitute a major obstacle to an effective HIV response" and threaten our ability to achieve an AIDS-free future. Likewise, the *PEPFAR Blueprint: Creating an AIDS-free generation (*US Department of State, p. 29*)* notes, *"*Key populations…typically have HIV prevalence rates that exceed those of the general population. However, stigma, discrimination and fear of violence or legal sanctions often undermine their access to health care, including HIV services. Breaking down these barriers is essential to achieving an AIDS-free generation."

CASE STUDIES

- **Senegal:** In December 2008, nine male HIV prevention workers were imprisoned for "acts against nature" prohibited by Senegalese law. Out of fear for their own safety, many well-established prevention programs serving hundreds of MSM stopped providing services after the arrests. Those who continued to provide services noticed a sharp decline in MSM participation.
- **Nigeria:** In the last three months of 2013, the Population Council provided more than 1,100 MSM with HIV prevention information and educational sessions. After the law passed in January 2014, this number dropped to zero, as peer educators began to resign and participants became harder to reach, changing phone numbers and even their names. Clinic-based services also suffered; in the Council's Kaduna clinic, turnout drastically dropped—from 916 MSM in the last quarter of 2013, to 108 MSM in the first quarter of 2014.

RESPONSES

National and international donors, policymaking bodies, and non-governmental organizations are wrestling with how to respond to the enforcement of recent anti-LGBT legislation. To effectively address these laws, any action or intervention must be carefully tailored to the specific local, regional, and country context. It will be important to consider the unique realities of (and potential reaction from) each individual community, and to develop these actions or interventions in close consultation with LGBT and public health leaders on the ground (Pulerwitz & Bongaarts, 2014; Downie, 2014).

Identifying the in-country decision-makers who recognize the importance of reaching MSM to stopping the spread of HIV will also be key. Yet, these champions will need the help of the wider public health community to provide the evidence and rationale for ensuring continued access to health and prevention services for MSM and other key populations. While some evidence exists, further research is needed, including research to better understand and document the health impacts of anti-LGBT laws, particularly on the HIV epidemic; research on the burden of HIV among MSM in Africa; and investigations into the most effective interventions for reaching MSM in countries with discriminatory laws. The Population Council and others are working to address these needs.

RESOURCES

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