S20 – CRIMINALIZATION, THE LAW AND SEXUAL HEALTH

Wednesday, July 17, 2019

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S20.1 UNDERSTANDING HOW LAWS AND POLICIES AFFECT HIV PREVENTION PRACTICES: A THEORETICAL APPROACH

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Laws and policies play a critical role in creating contexts for the prevention of HIV. Research for example shows that incriminating laws, and policy absences, prevent certain population groups from taking full advantage of existing HIV prevention services, constrain the development of new interventions, contribute to stigma and discrimination, and reinforce social disadvantage. While an enabling law and policy environment in the form of regulations and guidelines is central to the fight against HIV, reducing laws and policies to 'context', overshadows the complex mechanisms through which they come to have effect on HIV prevention practices. To support further research into how laws and policies shape HIV prevention practices, I explore the potential of social practice theory as an approach for interrogating how laws and policies mediate links between individual, community, and societal phenomena. I introduce a 'table of questioning' for identifying the range of material, symbolic, competence, relational and motivational law and policy elements that may affect HIV prevention practices. I argue that such exploration can facilitate analysis and action of the links and connections between laws, policies, elements, and social practices that establish (dis)engagement with HIV prevention practices as a possible and desirable thing to do. Such analysis can help uncover local hitherto un-identified issues and provide a platform for novel synergistic and combination prevention approaches for action that are not otherwise obvious.

Disclosure No significant relationships.

S20.2 INTERSECTIONALITY, CRIMINALISATION AND SEXUAL HEALTH

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Intersectional stigma converges with criminalization to produce sexual health disparities. The convergence of socially marginalized identities constrains sexual rights, as well as provides opportunities for resilience, resistance, and solidarity. This presentation explores how an intersectionality lens helps to elucidate the ways that criminalization shapes sexual health across diverse populations and contexts. This presentation draws from three community-based studies. Applying a multiple case study design to these studies provides the opportunity to examine broader themes of intersectionality and criminalization and how these shape sexual health across global contexts.

A qualitative study was conducted with lesbian, gay, bisexual and transgender (LGBT) persons in Lesotho, a country where same-sex practices were recently decriminalized but there remains no legal protection from discrimination for LGBT persons. A mixed-methods study was conducted with LGBT youth and gender diverse sex workers in Jamaica, where sex work and same sex practices are criminalized. Finally, a quantitative study was conducted with urban refugee youth in Uganda, where sex work is criminalized. We found that managing and negotiating sex—and in turn sexual health—was constrained by intersectional sexual rights violations. The ways by which persons were affected by criminalization differed based on intersectional identities, including gender, sex work and sexual orientation. By examining contexts of constrained sexual rights, we found that survival challenges included pervasive violence—including from police, limited healthcare access, employment & housing barriers, barriers to accessing prevention tools, and barriers to healthy relationships. Participants across contexts discussed awareness of, and strategies to navigate, these barriers to sexual health. Criminalization of sex work and LGBT identities constrains negative and positive sexual rights. An intersectional lens provides insights into both intercategorical complexity—shared and differential experiences across populations and contexts—and intracategorical complexity of lived experiences within socially marginalized groups. Findings can inform intersectional, structural-level sexual health interventions.

Disclosure No significant relationships.

S20.3 THE HEALTH IMPACTS OF SEX WORK CRIMINALIZATION: A REVIEW OF THE EVIDENCE

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Background Sex workers are at disproportionate risk of violence and sexual and emotional ill-health, harms that have been linked to criminalisation.

Methods We synthesised evidence on the extent to which sex work laws and policing practices, affect sex workers' safety, health and access to services, and the pathways through which these effects occur. We searched bibliographic databases for research with sex workers of all genders and terms relating to legislation, police and health. We operationalised criminalisation into categories of lawful or unlawful police repression of sex workers or their clients. We included quantitative studies measuring associations between policing and outcomes, and qualitative studies exploring related pathways. We conducted a meta-analysis to estimate the effect of experiencing physical/sexual violence, HIV/sexually transmitted infections (STI) and condomless sex, comparing individuals exposed and unexposed to repressive policing. We synthesised qualitative studies iteratively, inductively and thematically.

Results We reviewed 40 quantitative and 94 qualitative studies. Meta analyses suggest that on average sex workers who had experienced repressive policing were at increased risk of sexual/physical violence from any party (OR=2.99 95% CI=1.96–4.5, n=5204), increased risk of HIV/STIs (OR=1.87, 95% CI=1.60–2.19, n=12506) and more likely to practice condomless sex (OR=1.42 95% CI=1.03–1.94, n=9447) compared to those who had not. The qualitative

synthesis showed that criminalisation and repressive policing disrupted sex workers' safety and risk reduction strategies and access to health services and justice, including where clients are criminalised. Criminalisation and regulatory frameworks exacerbated stigma, racial, economic and other inequalities. In decriminalised contexts, sex workers' relationships with police have improved and they report being better able to refuse clients and insist on condom use.

Conclusions The evidence shows the increased harms associated with sex work criminalisation—including laws and enforcement targeting the sale and purchase of sex, and sex work organisation. These demonstrably harmful sex work policies and laws must be reformed urgently if sex workers' right to health is to be realised.

S20.4 CRIMINALISATION OF HIV TRANSMISSION IN THE ERA OF U=U

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Globally, HIV criminalisation continues to exacerbate and perpetuate HIV stigma and discrimination. Over 70 countries have laws that specifically criminalise HIV non-disclosure, exposure or transmission, and 39 countries have used existing criminal laws to prosecute people living with HIV. Society and criminal justice systems have failed to keep up with scientific advances of recent years and, in particular, our understanding of the powerful impact anti-retroviral therapy has on reducing HIV transmission risk. We now know that individuals on effective HIV therapy with an undetectable viral load do not transmit the virus to their sexual partners. This knowledge has not, as yet, translated into any significant change to the application of criminal law. The era of U=U (Undetectable = Untransmittable) should support our ability to use scientific evidence to end the criminalisation of HIV and the disproportionate impact this has on marginalised communities and those less able, for whatever reason, to achieve and maintain an undetectable viral load.

Disclosure No significant relationships.

S21 – BUILDING A HUMAN INFRASTRUCTURE FOR STI PREVENTION: BEYOND COMMUNITY ENGAGEMENT, CONSULTATION AND ADVISORY BOARDS

Wednesday, July 17, 2019
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S21.1 YOUTH AND COMMUNITY BASED RESEARCH

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This paper reports on the micro-, meso-, and macro-level impacts of creating and sharing digital stories created by Indigenous youth leaders about HIV prevention activism in

Canada. Eighteen participants created digital stories and hosted screenings in their own communities to foster dialogue. Data for this paper is drawn from individual semi-structured interviews with the youth leaders, audio-recordings of audience reflections, and research team member's field notes collected between 2012–2015 across Canada. Data were coded using NVIVO. A content analysis approach guided analysis. The process of sharing their digital stories had a positive impact on the youth themselves and their communities. Stories also reached policy makers. They challenged conventional public health messaging by situating HIV in the context of Indigenous holistic conceptions of health. The impact(s) of sharing digital stories were felt most strongly by their creators, but rippled out to create waves of change for many touched by them. Participatory visual methodologies can be powerful tools in creating social change and reducing health disparities.

Disclosure No significant relationships.

S21.2 ADDRESSING ANTI-LGBT STIGMA AND MEDICAL MISTRUST THROUGH A DATA-INFORMED APPROACH TO COMMUNITY ENGAGEMENT

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HIV disparities are an ongoing problem affecting LGBT populations, particularly Black gay, bisexual and other men who have sex with men (GBMSM) and transgender women (TGW). The etiology of these disparities is multi-factorial, but medical mistrust and anti-LGBT stigma are key barriers to HIV prevention and care access that likely contribute to disparities. A public health department and university-academic collaboration in partnership with clinical and community partners was funded to improve HIV prevention and care access among Black GBMSM and TGW. Recognizing medical mistrust and anti-LGBT stigma as significant prevention and care access barriers for these communities, the project included the development of Baltimore in Conversation (BIC), a program designed to understand and address these barriers. BIC engaged community voices through small-group conversations about lived experiences as LGBT persons, storytelling nights with presentations of personal narratives of resilience, and photo-story exhibitions of local LGBT persons. Innovative evaluation tools were designed and embedded within BIC. The evaluation sought, through qualitative and quantitative approaches, to inform programming with community perspectives and, ultimately, to determine whether BIC programming reduced medical mistrust and anti-LGBT stigma. The evaluation findings showed evidence of progress towards reducing medical mistrust and anti-LGBT stigma and provided community feedback used to make programming more relevant to experiences and needs of local LGBT communities. For example, analysis of small-group conversation transcripts provided community-informed and locally relevant language and images for an HIV prevention media campaign for Black GBMSM and TGW. Analysis of in-depth interviews of photo-story participants suggested participation led to reductions in internalized stigma and external stigma from important members of their social networks. This public health-academic collaboration created the opportunity to develop, evaluate and improve a public health program through a community-informed