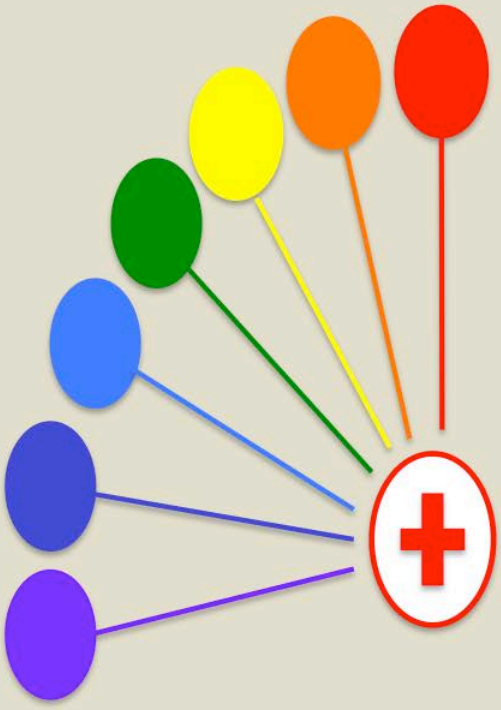

Rapid Assessment of HIV Prevention, Care and Treatment Programming for MSM in South Africa

Assessment Report

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMSHER	African Men for Sexual Health and Rights
AOR	Adjusted Odds Ratio
ART	Anti Retroviral Therapy
AU	African Union
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism (for the Global Fund)
CDC	Centres for Disease Control
CHC	Community Health Centre
CoP	Community of Practice
CVCT	Couples-based voluntary counselling and testing
DEBI	Diffusion of Behavioural Interventions
DoH	Department of Health
DPSA	Department of Public Service and Administration
DTHF	Desmond Tutu HIV Foundation
EC	Eastern Cape
ECGLA	Eastern Cape Gay and Lesbian Association
ECHO	Enhancing Children's HIV Outcomes
ELISA	Enzyme Linked Immunosorbent Assay
FS	Free State
GBV	Gender Based Violence
GF	Global Fund
GLAAD	Gay and Lesbian Alliance Against Defamation
GP	Gauteng Province
GTAFM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HIVOS	Humanist Institute for Cooperation
HSRC	Human Sciences Research Council
ICAP	International Centre for AIDS Care and Treatment Programmes
IDU	Intravenous Drug User
IEC	Information, Education and Communication
KAP	Knowledge, Attitude, Practice
KzN	KwaZulu Natal
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LP	Limpopo Province
MARPs	Most at risk populations
MEPI	Medical Education Partnerships Initiative
MMC	Medical Male Circumcision
MOU	Memorandum of Understanding
MP	Mpumalanga Province
MSM	Men who have Sex with Men
NACOSA	Networking HIV/AIDS Community of South Africa
NASTAD	National Alliance of State and Territorial Directors
NC	Northern Cape
NDoH	National Department of Health
NGO	Non Governmental Organisation
NIH	National Institute of Health (US)
NSP	National Strategic Plan for HIV, STIs and TB (2012-2016)
NW	North West
OVC	Orphans and Vulnerable Children

PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHRU	Peri Natal HIV Research Unit
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
RHRU	Reproductive Health Research Unit
RTC	Right to Care
SA	South Africa
SADC	Southern African Development Community
SAG	South African Government
SANAC	South African National AIDS Council
SANCA	South African National Council on Alcoholism
SHIPP	Sexual HIV Prevention Program
SMS	Short Message Service
SOHACA	Soweto HIV/AIDS Counsellors Association
STI	Sexually Transmitted Infection
SW	Sex Worker
SWEAT	Sex Worker Education and Advocacy Task Force
TB	Tuberculosis
TRIP	Translating Research into Practice
UAI	Unprotected anal intercourse
UCSF	University of California, San Francisco
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WC	Western Cape
WRHI	Wits Reproductive Health and HIV Institute
YMSM	Young men who have sex with men

BACKGROUND

Men who have sex with men (MSM) in South Africa are an under-served group in terms of HIV prevention, treatment, and care services. While HIV-related services in South Africa in general have been scaled up rapidly and effectively over the last decade this scale up has not included a specific focus on MSM. This is largely due to the generalised nature of the South African HIV epidemic. However, recent research with MSM in South Africa has revealed that, as in the rest of the world, these men have a high risk of HIV infection and are disproportionately affected by the HIV epidemic.

The purpose of this assessment is to provide a better understanding of responses to HIV for MSM populations, both by the government and non-governmental sectors, and to identify areas of need for enhanced programming.

The rapid assessment has been completed in the context of an increase in interest in MSM programming in South Africa and in the region, partly due to major funders such as the Global Fund and PEPFAR advocating for funding for this, and high level political support in South Africa from both the South African National AIDS Council (SANAC) and the National Department of Health. This assessment happens at a time when some proposed strategies and guidelines are still being planned but, at this point, MSM-targeted HIV prevention, treatment and care programming appears to remain minimal, and is regularly undertaken by NGO or community groups, and not taken to scale in the country.

This report provides a description of the programmes and services currently made available to MSM, and explores the extent to which research is being conducted in terms of the prevalence and incidence of MSM with HIV. The report also reviews perceptions of key role-players in terms of key gaps, areas of opportunity, and current priorities.

ASSESSMENT COMPONENTS

The rapid assessment includes the following core components:

1. Desktop review of published and grey literature on MSM in South Africa;
2. Desktop review of the South African policy environment for MSM;
3. Rapid review of existing and planned programming for HIV prevention, testing, counselling and treatment and care services;
4. Review of perceptions of MSM programming needs, gaps and priorities in terms of the above.

PART 1:
REVIEW OF AVAILABLE INFORMATION ON MSM IN SOUTH AFRICA

EPIDEMIOLOGY

MSM

Estimating the number of MSM in South Africa is difficult due to the lack of generalisable epidemiological research that has included questions on same sex behaviour. However, based on the data that is available, estimates of the total population of MSM range from 750 000[1] (Imrie et al., 2013) to 1 360 000[2] (Dunkle et al., 2013). The potential for more accurate methods of estimating population sizes of key populations in South Africa are discussed in more detail below (pg. 21).

One of the critical challenges related to developing HIV treatment, care and prevention interventions for MSM in South Africa is the diverse nature of the MSM population in the country. Because MSM is a broad behavioural category, it includes men who identify as heterosexual, homosexual, bisexual as well as biologically male transgender or gender queer individuals. In addition to comprising multiple gender

[1] Based on a figure of 3.2% of male participants in the HSRC's 2008 HIV prevalence survey reporting same sex sexual behaviours.

[2] This figure is our own calculation based on Dunkle et al.'s finding that 5.4% of their generalisable sample of South African men reported any lifetime consensual same sex sexual behaviour.

identities and sexual orientations, MSM in South Africa are also differentiated along racial, age, and socio-economic lines (cf. Tucker, 2009).

Adding further to the complexity of understanding MSM as a key population in South Africa is the fact that MSM social identities, social dynamics, and risky behaviours also differ geographically, both between particular regions, and across the rural/urban divide. Research on MSM in metropolitan areas in South Africa has documented diverse sexual and social identities. Sexual identities are also thoroughly entwined with race in South Africa. For example, several authors document the existence of fairly disparate sexual identities among MSM in Cape Town between various race groups (Swarr, 2004, Tucker, 2009, Visser, 2003). This in turn affects the social and sexual contexts of HIV risk among these men.

HIV RISK

HIV prevalence rates among MSM in South Africa range from 10.4% to 34.5% across different studies (Lane, 2013, Lane et al., 2011, Rispel and Metcalf, 2009, Tucker et al., 2013, Baral et al., 2011). Research with South African MSM has found that their risk of HIV infection is driven by multiple personal, interpersonal, and structural factors (Arnold et al., 2013, Knox et al., 2010, Nel et al., 2013, Tun et al., 2012, Jobson et al., 2013). In the studies reviewed, HIV risk was most frequently understood as inconsistent condom use for anal intercourse. However, several studies also used HIV positive status as an indicator of HIV risk.

At a personal level HIV risk in the South African MSM population has been found to be associated with: sexual identity (Lane, 2013); mental health status (Tucker et al., 2013); endorsing HIV related conspiracy beliefs (Tun et al., 2012); beliefs about trust and condom use in intimate relationships (Knox et al., 2010); and drug and alcohol use (Lane et al., 2008c, Parry et al., 2008). Vu et al. (2011) report high levels of internalised homophobia in their sample of MSM from Tshwane (Pretoria), and note an association between internalised homophobia and HIV related misinformation, which in turn affects individuals' likelihood of engaging in risky behaviours. Importantly, these personal factors are also affected by MSMs' relationships with each other and with the communities they live in.

Several studies have documented the interpersonal and local level community factors that affect HIV risk among MSM. The high levels of discrimination experienced by MSM across the country have been repeatedly documented (Baral et al., 2011, Cloete et al., 2008, Lane et al., 2008a, Rispel et al., 2011, Jobson et al., 2013), and have been linked to HIV risk among MSM. Baral et al. (2011), for example found that human rights violations were common in their sample of MSM in Cape Town, and that being blackmailed was significantly associated with HIV infection (Baral et al., 2011). Discrimination and the fear of discrimination at clinics and health care centres has also been documented in several studies, particularly with regard to seeking

care for sexually transmitted infections (STIs) (Lane et al., 2008a, Rispel et al., 2011, Jobson et al., 2013). Delaying or neglecting treatment for STIs is an important risk for HIV transmission.

The intimate relationships between MSM also directly affect their risk of HIV infection. In their discussion of contextual factors associated with unprotected anal sex in a sample of MSM from Soweto, Arnold et al. (2013) found that rates of unprotected anal intercourse were significantly higher with partners described as 'regular', and the authors suggest that a focus on trust, love and the regularity of anal intercourse in HIV prevention interventions for MSM may be a useful complement to other HIV prevention initiatives.

The broader contexts in which MSM live have also received attention as important factors driving HIV risk. These contexts include the socio-economic, and the cultural aspects of MSM's lives. Cultural and religious contexts that include intolerance of homosexuality may contribute to HIV risk directly and indirectly through various causal paths. Indirectly, these contextual factors may contribute to depression and lower self-esteem, which have been linked to increased rates of unprotected anal intercourse (cf. Alvy et al., 2010, Tucker et al., 2013). More directly, social exclusion due to homophobic cultural and social contexts limits the ability of MSM to access care and appropriate HIV prevention materials (such as condoms, water based lubricants, and MSM specific risk reduction information), which in turn increases their HIV infection risk (Arnold et al., 2013, Jobson et al., 2013).

HIV TRANSMISSION

The likelihood of transmission of HIV between MSM is dependent on several factors, including: the route of acquisition, the infecting viral load, and the presence of inflammation and activated immune system cells below mucosal surfaces. In terms of sexual risk, unprotected anal intercourse, and particularly receptive anal intercourse carries a very high risk of HIV transmission, approximately 18 times that of penile-vaginal intercourse (Rebe et al., 2011a).

HIV transmission is also affected by the presence of other STIs. For example, prevalent herpes simplex virus type 2 (HSV-2) has been found to be associated with a threefold increased risk of HIV infection (Freeman et al., 2006); similarly, syphilis (Buchacz et al., 2004) and gonorrhoea and Chlamydia (Bernstein et al., 2010), are also associated with increased risk of HIV infection.

HIV PROGRESSION

The progression of HIV infection to AIDS is also affected by a range of factors. Broadly, these can be classified as lifestyle/behavioural and HIV management related factors, immune system factors and infection and co-infection specific factors.

In terms of lifestyle and behaviour related factors, HIV progression is affected by heavy alcohol consumption, with alcohol having a negative impact on CD4 count in HIV positive individuals not receiving ART (Samet et al., 2007), additionally alcohol and drug use may negatively affect adherence to ART regimes, which also has negative impacts on HIV progression (Hinkin et al., 2004). Adherence to ART is critical in managing HIV progression and there is a range of issues that need to be considered in working with HIV positive MSM with regard to medication adherence. Stoloff et al. (2013), for example, note the high burden of common mental disorders among MSM attending Health4Men's clinic in Cape Town, and point to the importance of understanding the role of mental health in affecting ART adherence. Equally, medication adherence may be negatively affected by individuals' socio-economic status (Geng et al., 2010, Sahay et al., 2011), and local levels of HIV related stigma (cf. Rao et al., 2007).

Individuals immune response to HIV infection may also vary, and this in turn can affect the rate at which their infection progresses. Equally, the particular strain of HIV with which individuals are infected may also influence the rate at which their disease progresses. Co-infection with other viruses and infectious diseases may also affect HIV progression.

KEY MSM GROUPS

Research in South Africa on HIV among MSM to date has tended to take a rather undifferentiated view of the MSM population. Where differences are noted these tend to be based on race, residential location (peri-urban townships vs. urban/suburban), or substance use. While this research has revealed a range of important issues that need to be addressed in HIV prevention for MSM, there remains a need for more granular and nuanced approaches to this population. Based on both local and international literature, we note the need for an increased focus on: age group, relationship status, sex work, HIV positive MSM, and substance use in work with MSM. A more differentiated and targeted approach to HIV prevention is likely to enable organisations to tailor interventions and messaging to specific population groups based on their specific needs.

YOUNG MSM

There is very limited research in South Africa that focuses on young (aged <25) MSM specifically. However, international evidence suggests that these men may have a relatively high risk of HIV infection (Valleroy et al., 2000). Beck et al (2012) note that young MSM (YMSM) face a number of unique vulnerabilities that increase their risk of HIV infection. Where YMSM are dependent on their families for income, housing, and support, they are at risk of losing these resources if their sexuality is not accepted by their family members (Beck et al., 2012). The loss of stable housing and income are both associated with increased HIV risk (Leaver et al., 2007). Globally, Beck et al (2012) found that YMSM experienced significantly higher levels of homophobia and violence than older MSM, and simultaneously reported lower levels of community engagement, comfort with service providers and connection to the gay community than older MSM. The combined effect of these factors increases HIV risk for YMSM by limiting their access to support services and HIV prevention resources (Beck et al., 2012).

It is clear then that YMSM may face challenges related to disclosing their sexual orientation or sexual behaviours in various contexts, including within their families, among friends, and in health care settings. The broadly homophobic nature of South African society means that disclosure, or coming out as gay, is a potentially risky undertaking which may lead to withdrawal of support, and increased stigma, violence, and discrimination (Henderson and Shefer, 2008). This in turn may increase individuals' risk of HIV infection through the mechanisms noted above.

Other studies, primarily in the United States, have identified a range of risk factors for HIV infection among YMSM. These include: having high lifetime numbers of male sex partners (Valleroy et al., 2000); lower levels of education (Balaji et al., 2013); alcohol and drug use prior to sex (Newcomb, 2013, Balaji et al., 2013); experiences of violence or threats of violence (Koblin et al., 2006); intimate relationship characteristics (Mustanski et al., 2011); and having an older partner (Mustanski et al., 2011).

It is likely that some or all of these issues also affect young MSM in South Africa, but research is lacking. One study conducted with YMSM at a South African university found relatively high levels of consistent condom use (70% reported always using condoms), but also noted the relative frequency of experiencing violence and abuse, as well as alcohol and drug use during sexual intercourse (Brink, 2012).

Data from Ivan Toms Centre for Men's Health shows that there are also differences between younger and older MSM in terms of their sexual identities and race. Among black clients, younger MSM were more likely to self-identify as gay or homosexual, while older MSM tended to identify as bisexual; this difference did not exist among white or coloured clients (Jobson et al., 2011). Differences in sexual identity may be associated with differences in HIV risk, and Lane (2013) for example, found that gay

or transgender identifying participants in their study in Mpumalanga had higher odds of testing positive for HIV than those who identified as straight or bisexual.

HIV-related interventions targeting YMSM specifically are likely to form an important part of the evolving response to the HIV epidemic in key populations in South Africa. By targeting YMSM as a group in their own right it will be possible to tailor interventions to address the specific needs and challenges faced by these individuals, which will have long term effects on their HIV risk across their lifetimes.

OLDER MSM

Following the logic of age group specific HIV interventions, it is also necessary to examine the HIV risks among older MSM (older than 45 years) in South Africa. Sankar et al (2011) note that age can be conceptualised as both the chronological age of the biological body, and the cultural life course stage. A life course stage is defined by a society's age-related expectations and its norms around socially constructed age groups and the transitions between these age groups (Sankar et al., 2011). Both the biological and social aspects of aging may therefore affect older MSM's HIV risks.

In terms of the socio-cultural aspects of aging, the social and sexual norms and expectations for older MSM may differ substantially from those of other men in their age group, and these norms and expectations could also affect their HIV risk (Lyons et al., 2010). Murray and Adam (2001) for example found that older gay men experience concerns about living up to the idealised standards of younger gay men, fears about losing their desirability, and feelings of worthlessness. Older gay men also suffered from depression and isolation more frequently than younger gay men (Murray and Adam, 2001). Heath et al. (2012) note that these psychosocial factors may lead older gay men to engage in riskier sexual behaviours as a means of attempting to fulfil their emotional needs.

It is also important to understand that patterns of well-recognised HIV risks may differ between younger and older MSM, and that it is not necessarily appropriate to target older and younger MSM with the same types of interventions (cf. Salomon et al., 2008).

In terms of the biological aspects of the aging process, the increasing rates of erectile dysfunction associated with increased age may also affect HIV risk (Heath et al., 2012). For example, older MSM may be tempted to forgo condom use if they find that using condoms makes it more difficult for them to get or maintain erections. Becoming infected with HIV at an older age may also be associated with more severe consequences in terms of declines in health and decreased survival times (Centers for Disease Control, 2007).

There is, again, a lack of research with older MSM in South Africa, but there are likely to be some parallels between older MSM globally and those in South Africa. Examining what research is available, Lane (2013) found higher rates of HIV infection among older (>25 years) MSM respondents in Mpumalanga. In an online survey of MSM who use drugs in South Africa, Jobson (2012) found that the MSM reporting the highest rates of drug use in unprotected sexual encounters were on average 40 years old, and that these men reported using drugs specifically to increase their enjoyment of sex and to lose their inhibitions.

MSM RELATIONSHIPS

The relationships that MSM engage in may have direct effects on their risk behaviours, as well as providing an effective context in which to implement HIV prevention interventions. In terms of HIV risk, Arnold et al. (2013) found that participants in the Soweto Men's Study who reported sex partners as 'regular' were more likely to report unprotected anal intercourse with these partners. This finding is also important in light of Sullivan et al.'s (2009) estimation that 68% of HIV transmissions in their US sample were from main sex partners. This was due to the higher number of sex acts with main partners, more frequent receptive anal intercourse and lower levels of condom use with these partners (Sullivan et al., 2009). Data on HIV transmission rates between MSM couples in South Africa are lacking, but based on studies with heterosexual couples in other parts of sub-Saharan Africa (Dunkle et al., 2008), it is likely that this is an issue worth focusing on.

The relationship context also provides a basis for targeted HIV prevention interventions. One such intervention is couples-based voluntary counselling and testing (CVCT). As the name suggests, CVCT involves couples testing for HIV together, receiving pre- and post-test counselling, and risk reduction counselling appropriate to their couple sero-status (sero-concordant positive or negative, or sero-discordant) together (Stephenson et al., 2012). CVCT has been shown to be effective in reducing sexual risk taking among heterosexual couples in other parts of Africa, and Stephenson et al. (2012) found a high level of acceptance of CVCT among MSM couples in Cape Town.

In addition to the provision of CVCT, there is a need for sensitisation of health care workers more generally in their work with MSM. In particular, there is a need for health care workers to avoid adopting heteronormative attitudes in their work with MSM (Rebe et al., 2013a), and to avoid making assumptions about the sex of individual MSM's sexual partners.

Given the high rates of UAI with regular partners reported by Arnold et al. (2013) it is likely that sensitively implemented interventions focusing on couples could have a positive impact on HIV transmission rates among MSM in South Africa.

MSM, SEX WORKERS AND TRANSACTIONAL SEX

Sex worker populations globally have a high risk of HIV infection due to their multiple overlapping vulnerabilities (Wariki et al., 2011). These vulnerabilities are in part due to the living and working conditions of sex workers. The direct HIV risks associated with sex work include: high numbers of sex partners with different social backgrounds and sexual histories; exposure to higher than average numbers of STIs; unprotected sexual intercourse; and injecting drug use by either sex workers or their partners (Wariki et al., 2011).

Indirect risk factors that increase sex workers vulnerability to HIV infection include social marginalisation and exclusion; the criminalisation of sex work and victimisation by police (Arnott and Crago, 2009). Knowledge of HIV transmission risks associated with male-male sex may also be lacking among sex workers, and research with male sex workers in Kenya found that 35% of respondents did not know that HIV could be transmitted through anal sex, while 21.2% did not know that water based lubricants should be used with condoms for anal sex (Geibel et al., 2008). There is a lack of South African specific data on male sex work, however, Richter et al (2013) report that in their study of male, female, and transgender sex workers in four South African cities male sex workers were 2.9 times (AOR, 95% CI 1.6 – 5.3, $p<0.001$) more likely than female sex workers to have unprotected sex. Daily and weekly binge drinking were also noted as risk factors among male sex workers in this study, with 59.7% reporting feeling drunk at last sex with either of their previous 2 clients, and overall (across male, female, and transgender sex workers), daily or weekly binge drinking was associated with a 2.1 times (AOR, 95% CI 1.2 – 3.7; $p=0.011$) higher likelihood of reporting unprotected sex (Richter et al., 2013).

Another risk associated with sex work among MSM is substance use. Hallet (2003) for example documents how male sex workers in his study used drugs as a coping mechanism to help them deal with the demands of their work. Similarly, research globally has also documented high rates of substance use among male sex workers, and has found that substance use is a risk factor for HIV transmission in this population (Baral et al., 2010, Mimiaga et al., 2009, Tun et al., 2008, Wechsberg et al., 2005). Boyce and Isaacs (2012) report that male sex workers from South Africa who participated in their assessment of social contexts, risks and practices among men selling sex rated substance use as the largest general threat facing sex workers. In line with this finding, Needle et al. (2008) found that drug use was common among both male and female sex workers in South Africa, and that using drugs was intimately associated with sex workers daily routines and their sexual interactions with clients.

In discussing sex work and transactional sex in South Africa, it is worth distinguishing between sex work as a form of employment, and occasional transactional sex in the context of individuals social lives. This distinction is important because the social context of HIV risk, including the motivations and processes behind negotiating

sexual encounters differs markedly in these interactions. In research conducted with MSM in Cape Town, sexual interactions between men during their normal patterns of socialising were reportedly frequently characterised by a transactional element (Jobson et al., 2013). Generally the 'transaction' would involve individuals buying alcohol for potential sex partners, who were frequently heterosexually identifying (known colloquially as "after nines")(Jobson et al., 2013). MSM also report being paid for sex, and in unpublished data from Health4Men's Ukwazana Study, 31.5% (95/302) of participants reported receiving some form of payment for sex, while 32.9% (100/304) reported paying someone else for sex, and 19.2% (57/297) reported both paying for sex, and receiving payment for sex. Notably, these sexual encounters were most frequently reported to occur in the context of alcohol use, and several participants noted forgoing condom use either due to being intoxicated or out of fear of losing the opportunity to have sex (Jobson et al., 2013).

MSM DRUG USERS

Substance use may directly affect HIV risk behaviour, and internationally, associations between sexual risk taking and substance use have been repeatedly documented (cf. Aguinaldo et al., 2009, Benotsch et al., 1999, Carey et al., 2009, Choi et al., 2005). Aside from incidental use of drugs in contexts where men have sex with each other, drugs are also used specifically to enhance sexual interactions. Drug use may play a range of roles in MSM's sex lives and Myers et al. (2004) outline six of these, noting that MSM may use drugs in sexual interactions as a means of: generally enhancing the sexual experience; increasing sexual arousal; facilitating sexual encounters; increasing the capacity to engage in particular sexual activities; increasing the length of sexual interactions; and facilitating sex work.

In South Africa research has revealed distinct differences in drug use among MSM by racial group, economic status, and geographical location. Among black MSM alcohol appears to be the most frequently used substance, and Lane et al. (2008c) found an increased risk of unprotected anal intercourse among MSM in their study in Soweto who reported regular drinking. Jobson et al. (2013), in a qualitative study in Cape Town, found that black MSM directly associated risky sexual behaviour with being under the influence of alcohol. Where research has documented the use of other substances among township dwelling MSM in South Africa, marijuana appears to be the main substance used, and rates of using harder drugs such as cocaine, crystal methamphetamine, ecstasy, heroin or mandrax are reportedly low (Lane et al., 2008c). Generally, the use of harder drugs among black MSM seems fairly limited, with the exception of black MSM who work as sex workers (Parry et al., 2008).

Among the white, coloured and Indian MSM population the use of a variety of drugs appears to be more widespread. In a small sample of MSM attending Ivan Toms Centre for Men's Health in Cape Town, Stoloff et al. (2013) found a high prevalence

of drug use disorders (56%). In Health4Men's (2012) online survey of MSM in South Africa 35.5% of white participants, 18.6% of black participants, 31.9% of coloured participants, and 18.9% of Indian participants reported any drug use in the previous 6 months. Data from this survey also show significant differences between HIV positive and HIV negative MSM in terms of their drug use and sexual risk behaviours (Jobson, 2013b). For example, 22.3% of HIV positive MSM reported using crystal methamphetamine to enhance their sexual encounters, compared to only 3.9% of HIV negative MSM; and 42.5% of HIV positive participants reported more than one session of group sex in the previous 6 months, in comparison to 28.7% of HIV negative participants (Jobson, 2013b). These findings are possibly related to reports of the use of crystal methamphetamine in the context of sex parties organised exclusively for HIV positive MSM, an occurrence reported in focus group discussions with drug using MSM in Cape Town (Health4Men, 2012). Parry et al. (2008) similarly noted that MSM in their rapid assessment of drug use and HIV risk reported using drugs in the context of group sex.

More broadly, Mitchell (2013), reporting data from Health4Men's (2012) online survey, found that among MSM who reported daily drug use HIV prevalence was 54%, that 47% reported 7 or more sex partners in the previous 6 months, and that 92% reported inconsistent condom use in the previous 6 months. These findings clearly point to a need for HIV prevention initiatives focusing on substance use among MSM in South Africa.

PRISONERS

The HIV prevalence among South Africa's prisoner population was estimated at 45% in 2006 (United Nations Office on Drugs and Crime, 2007), and around 97% of inmates in South Africa are male (Department of Correctional Services, 2011). Being imprisoned presents a high risk of HIV infection for these men, with sexual activity and anal sex being a key risk factor for HIV transmission in this context. Other important risks include the use of contaminated cutting equipment for drawing tattoos, and to a lesser extent in the South African context, injecting drug use (Goyer, 2003).

Both consensual sex and sexual assault present particular challenges for HIV prevention in the prison context in South Africa. The Jali Commission of Inquiry (2006) found high rates of sexual violence in South African prisons, and this violence is frequently linked to gang activities within these prisons. Consequently, the establishment of sexual relationships between prisoners is often linked to processes of dominance and subordination, and may form an intimate part of gang ritual and lore (Gear, 2005).

It is important to note that consensual sex also takes place between men in prison (Gear, 2005), and that this may or may not occur between men who self identify as homosexual. The occurrence of consensual sex between men in environments such

as prisons, the military, or mining hostels has been described by Parket et al as the "situational specificity" of erotic desire. (Parker et al., 2000)

There is a clear need, given the high HIV prevalence among prisoners, and the frequent sexual interactions between them, to focus attention on interventions promoting the use of condoms and water based lubricants for anal sex in this context. There is also a clear need for interventions addressing sexual violence and rape in South Africa's prisons.

STRUCTURAL ISSUES IMPACTING MSM

Structural factors affecting HIV risk are the social, economic, political and environmental issues that directly and indirectly affect individuals risks of acquiring HIV through multiple causal pathways (Rao-Gupta et al., 2008). A central tenet of the call for combination HIV prevention interventions is the recognition that the ability of individuals to implement risk reducing behaviours is strongly affected by the contexts in which they live (Coates et al., 2008). As Coates et al. (2008 p. 36) note, "HIV prevention is neither simple nor simplistic", and in order to sustain the changes in behaviour required to reduce HIV transmission, the multiple, multi-level drivers of HIV risk need to be addressed.

For MSM in South Africa particularly important structural issues affecting HIV risk include: high levels of stigma and discrimination from multiple sources (Jobson et al., 2013, Lane et al., 2008a, Rispel et al., 2011, Cloete et al., 2008, Vu et al., 2011); cultural and religious beliefs about the unacceptability of homosexuality (Jobson et al., 2013); lack of access to appropriate HIV prevention, treatment and care (Rispel et al., 2011, Lane et al., 2008a); and poverty and a lack of economic opportunities, including lack of access to the social grant system (Jobson et al., 2013). In contrast, Arnold et al. (2013) note increases in HIV risk associated with higher income levels among MSM in Soweto, which may point to the dual role of poverty and local level income inequality as interacting factors affecting HIV risk. Indeed, Scheibe et al. (2013) note the importance of considering both poverty and increasing levels of inequity as drivers of HIV risk among MSM in Cape Town. The potent mix of social exclusion, direct experiences of homoprejudice, lack of access to power and resources and lack of access to income earning opportunities combine to increase MSM's HIV risk through multiple causal pathways.

Examples of these include: negative effects on individuals mental health statuses, which in turn have been linked to increased HIV risk (cf. Salomon et al., 2009); high levels of homophobia in individuals' local communities may lead MSM to hide their same-sex sexual practices, reducing the likelihood of their accessing appropriate HIV prevention materials (such as water based lubricants) (Jobson et al., 2013); and homophobic social contexts create the potential for human rights abuses and

blackmail, which were linked to less frequent HIV testing and denial of health care in Baral et al.'s (2009) study.

Another structural factor of central importance to HIV risk among MSM is the policy context of the countries in which they live. As Scheibe (2013) notes, while the broad policy context in South Africa is supportive of MSM rights, the ability to enjoy the freedoms enshrined in the Constitution is still linked to individuals' power and resources. Further, the degree to which the constitutional enshrinement of individuals' rights is reflected in the policies and programmes implemented by government departments at national, provincial and local level varies. The MSM-related policy context in South Africa is discussed in more detail below.

SOUTH AFRICAN MSM POPULATION SIZE ESTIMATES: CURRENT STATUS

South Africa does not have accurate populations size estimates for the MSM population, although some plans are in place for a more detailed assessment. Some national level data exists from The Human Sciences Research Council's (HSRC) 2008 National HIV Prevalence, Incidence, Behaviour and Communication Survey (Shisana et al., 2009). Results from the 2012 survey have not yet been fully released: no MSM-related data has been presented in the initial conference presentations from this study (Shisana, 2013).

In the HSRC 2008 survey 3.2% of men self reported same sex behaviour, which would be equivalent to approximately 750,000 men nationally. Dunkle et al. (2013) reported on a population based survey of men from randomly selected households in the Eastern Cape and KwaZulu-Natal provinces, in which 5.4% of men reported at least one lifetime occurrence of consensual sexual contact with a man. If this proportion were extrapolated nationally, it would suggest in the region of 1.2 million MSM. In this study, there were no significant differences in the prevalence of consensual male–male sexual behaviour by race, age, education, or recent employment. Almost all the MSM in this study (98.9%) had had sex with a woman.

Population size estimates are important to target both HIV prevention and treatment services, and plans are in progress to extend a UCSF-led approach to population size estimates, which has been used in other African countries, and in other key populations in South Africa, to MSM in 2014. This approach is described below, with an example from a recently completed exercise undertaken by UCSF and Anova in Mpumalanga.

MSM Population Size Estimation Methods

In the absence of a gold standard methodology to estimate the size of a given population, current estimates are imprecise and prone to potential biases. Using multiple estimation methods, however, improves the validity of the estimate and is useful for local, provincial, and national health program planning purposes. Current estimation projects in South Africa, conducted by University of California, San Francisco (UCSF) utilize three approaches to produce the most rigorous estimates of key populations, in this case, men who have sex with men (MSM). The use of multiple methods strengthens confidence in estimates, provides upper and lower plausibility bounds, and reduces the likelihood that biases of any single method will substantially alter results. The following describes the three methods currently employed:

Method 1: Modified Delphi. This method produces an estimate of the number of MSM in the targeted communities through the synthesis of local and international expert opinion. A synthesis of data from an extensive review of the published and grey literature is conducted, searching for relevant data from South Africa and similar regions. Additionally, members of the target community are also asked their best estimate of the number of MSM "In and around" the study sites. This approach has also been called the "Wisdom of the Crowds Method". Such an approach produces a measure of the perception of community members and providers of the population size of MSM.

Method 2: Unique Object Multiplier. Procedures for unique object multipliers entail two basic steps:

1. Distribution of a fixed number of memorable, unique objects (e.g., a glass bead bracelet with a distinct pattern) to members of the study population in the geographic area of the study.
2. Re-sampling this area of study and asking whether study participants had received the unique object.

Using these two data sources, the multiplier method provides a population size estimate by the formula:

$N = n / p$

Where N is the estimated MSM population size, n is the total number of unique objects distributed in the study location, and p is the proportion of MSM reporting in the follow-up survey that they received the unique object.

To strengthen accuracy and recall, there should not be a long lag-time between the disbursement of the unique object and the re-sampling of the community. Additionally, outreach workers who hand out the object should be memorable (e.g. wearing a red hat) to decrease recall bias.

Method 3: Unique Event Multiplier. Similar to the Unique Object method, rather than "tagging" MSM with an object, a memorable event is held (e.g., mobilization fair, house party) that records the number of unique individual MSM in attendance. Prior experience with other MSM populations in Ghana, Kenya, and Mozambique have shown that timing these events with the launch of a survey helps publicize the survey aims and goals throughout the community, facilitating timely achievement of recruitment goals. The event is followed by a follow-up survey, which asks if the respondent attended the event. The number of MSM counted attending the event and the proportion reporting attending in the follow-up survey provide the parameters for the formula in Method 2 above.

AN EXAMPLE OF MSM POPULATION SIZE ESTIMATES IN MPUMALANGA

A collaborative team from UCSF and the Anova Health Institute, under the leadership of Dr Tim Lane, has recently completed data collection on the Mpumalanga Men's Study in the Gert Sibande and Ehlanzeni districts of Mpumalanga province (Lane, 2013).

To determine the number of men who have sex with men (MSM) living in Gert Sibande District and Ehlanzeni District, Mpumalanga, South Africa in 2012/2013, this group applied several, practical population size estimation methods during the Mpumalanga Men's Study (MpMS) and synthesized findings to determine plausible estimates. The range of estimates determined by the various methods yielded the following estimates for MSM in Gert Sibande: 1,810 (1.2%) from literature review, 1,363 (0.9%) by unique object multiplier, 696 (0.5%) by unique event multiplier and 624 (0.4%) by wisdom of the crowds (WOTC). Using the same methods as in Gert Sibande, population size estimates of MSM in Ehlanzeni included 2,049 (1.2%) from literature review, 3,833 (2.2%) by unique object multiplier, 324 (0.2%) by unique event multiplier and 2,491 (1.5%) by wisdom of the crowds (WOTC). The point estimates adopted via a consensus review as being most plausible were 1,363 (0.9%) for Gert Sibande and 2,049 (1.2%) for Ehlanzeni. This process emphasizes that there is no gold standard for estimation population sizes among key populations at risk for HIV and thus no one method can conclude the size estimate of MSM in these two municipalities in Mpumalanga. The estimates that the researchers found, though still not perfect, are useful as a basis for the HIV programmes serving these populations.

PART 2:
MSM IN SOUTH AFRICA – A REVIEW OF THE POLICY ENVIRONMENT

MSM POLICY INTRODUCTION

The policy environment in which MSM-related HIV prevention, treatment and care interventions operate is centrally important in determining the range of possibilities for such interventions, as well as determining, to some extent, the level of involvement possible from government services and employees. In South Africa the broad policy environment affecting HIV interventions for MSM and other key populations is determined by both government and donor policies.

While there has been a supportive policy environment for MSM-related interventions since the drafting and promulgation of the South African Constitution in 1996, in reality, it is only in the last 5 years that MSM have been focused on as an important part of the response to HIV in the country. Indeed, as Rispel and Metcalf (2009) note with regard to the previous National Strategic Plan (NSP) on HIV and AIDS and Sexually Transmitted Infections (2007 – 2011), "*…health services remain largely unresponsive, and no dedicated funding has been allocated by government to meet the targets outlined in the NSP.*" In this context, the bulk of HIV interventions targeting MSM and other key populations have been implemented by NGOs with donor funding. The policies of major donors (notably PEPFAR and the Global Fund) have thus also played an important role in shaping the policy environment in which interventions are implemented.

SOUTH AFRICAN GOVERNMENT POLICY AND HIV IN MSM

At the broadest level, the South African Constitution outlaws discrimination against anyone on the basis of his or her sexual orientation, and South Africa remains the only country in Africa that explicitly prohibits such discrimination. In terms of health care and social policy, however, explicit mention of MSM and other key populations remains rare.

The South African National AIDS Council (SANAC) is responsible for drafting the NSP and for monitoring its implementation as part of its mandate in overseeing the country's response to HIV. The NSP provides the basis for both strategic and operational plans in the individual provinces. As noted above, while both the previous (2007 – 2011) and current (2012 – 2016) NSPs include MSM and key populations, there remains a lack of operational guidelines and specific policy measures at both national and provincial level to ensure that targets outlined in the plans are implemented.

The current NSP is structured around four strategic objectives: 1) address the social and structural drivers of HIV, STIs, and TB; 2) prevent new HIV, STI, and TB infections; 3) sustain health and wellness; 4) ensure protection of human rights and improve access to justice. These four objectives include sub-objectives, and while MSM are implicitly included across the main objectives, only 2 sub-objectives make explicit mention of this population. Sub-objective 2.5. notes the need to work on strategies around implementing Pre-Exposure Prophylaxis (PrEP) for MSM; and sub-objective 3.1. outlines the necessity of making concerted efforts to reach MSM with appropriate screening, diagnosis, and treatment.

While the NSP provides the basis for provincial departments' planning processes, only two provinces explicitly include MSM in their current strategic plans. In KwaZulu-Natal (KzN), MSM are included as a key population in their table of combination interventions aimed at preventing HIV and STI transmissions (Office of the Premier: Province of KwaZulu-Natal, 2011). This table includes a range of intervention types, including: condoms, PEP, HCT, TB screening, MMS, Behavioural Change Campaigns, STI treatment, PrEP, PMTCT, and "addressing contextual"; and notes the applicability of each of these for each key population.

The Western Cape also explicitly includes MSM in their Provincial Strategic Plan on HIV/AIDS, STIs and TB (Western Cape Department of Health, 2012). This plan includes MSM with other key populations as requiring services, noting the responsible sector as "civil society"; MSM are also included in a sub-objective focusing on reducing HIV and TB related stigma and discrimination, where MSM-training for health workers is noted as a priority activity (Western Cape Department of Health, 2012). The use of PrEP in MSM is also noted as an area requiring further work to develop strategies for implementation and to understand the feasibility of its implementation (Western Cape Department of Health, 2012).

MSM do not appear to be mentioned in the policies or strategic plans of other provincial health departments, or other government departments more generally. Guidelines for HCT, ART and other aspects of HIV and STI management do not mention MSM. However, the consensus committee of the Southern African HIV Clinicians Society has developed guidelines for the safe use of PrEP among MSM (Bekker et al., 2012).

SOUTH AFRICAN GOVERNMENT POLICY REGARDING OTHER KEY POPULATIONS

Apart from MSM, other key populations with increased risk of HIV infection in South Africa include: transgender populations, sex workers, injecting drug users, prison populations and specific migrant groups (Scheibe et al., 2011). These populations are also included in the NSP as requiring a specific focus in HIV prevention, treatment, and care programming (SANAC, 2012). However, the policy environment for these different groups differs somewhat from that of MSM.

In the case of sex workers and injecting drug users, a key challenge in the policy environment is the fact that sex work and the possession and use of drugs remain illegal in South Africa. The illegality of these activities negatively affects the ability of individuals to access relevant health services, and jeopardises the implementation of targeted HIV prevention programmes for these groups.

In terms of cross-border migrants, while legislation exists to ensure their access to HIV related services, in practice access to these services may be difficult and may be particularly difficult in cases where individuals have outstanding documentation or whose legal status is not yet confirmed (Scheibe et al., 2011).

The right of transgender people to change their gender is legislated in South Africa (Scheibe et al., 2011). The Alteration of Sex Description and Sex Status Act No. 49 of 2003 allows for individuals to legally change their gender and provides for those who are in various stages of transition. It is not limited to those who have undergone reassignment surgery. However, transgender populations still face high levels of stigma and discrimination in health services, the Act is poorly implemented by the Dept. of Home Affairs and transgender people are denied identity documents or experience excessive delays and there remains a lack of HIV related services focusing specifically on transgender populations. There is no formal national Transgender Health Policy or Curriculum, although there are guidance documents on transgender care issued by a local NGO, GenderDynamix (Muller, 2013).

DONOR POLICIES

The policies of major international donors to HIV-related programmes have played an important role in raising awareness of the need to address MSM and other key populations in HIV prevention, treatment and care in South Africa, as well as in supporting the initiation of projects focusing on these populations. The two largest donors funding HIV-related work in South Africa are PEPFAR and The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Parsons et al., 2011).

In 2011 PEPFAR published guidelines for combination HIV prevention for MSM (PEPFAR, 2011). This technical guidance on HIV prevention for MSM emphasises the need to address the complex drivers of HIV risk among MSM, and defines the core elements of such a prevention package as:

1) Community based outreach
2) Distribution of condoms and lubricants
3) HCT
4) Linkage to care
5) Target information, education and communication (IEC)
6) STI prevention, screening and treatment.

As one of the major donors supporting MSM related HIV programming in South Africa, PEPFAR's approach to this programming forms the basis of much of the current work underway in this area.

The Global Fund's approach to working with MSM, transgender people, and sex workers, is outlined in their 2009 document titled "The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities" (The Global Fund, 2009). This strategy outlines 19 actions to be taken to support programming that is inclusive of MSM, transgender people and sex workers. These actions include internal procedural changes (such as modifying guidelines for proposals), changes to monitoring and evaluation processes, working to increase budget allocations to programmes focusing on MSM, transgender populations and sex workers, and supporting trainings and briefings around these issues for Global Fund Partners (The Global Fund, 2009).

The increased focus on MSM and key populations by these two donors has had a direct impact on the number of interventions working in this area in South Africa, and in doing so it is likely that they have also contributed towards creating a more supportive policy environment for such interventions.

NATIONAL POLICIES IN DEVELOPMENT OR UNDER REVIEW

Several new policies are at a late stage of development or review by the National Department of Health, which will address relevant issues for MSM. Three of these are at the stage of stakeholder review, and should be finalised and published in the near future.

The National Department of Health has developed "Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa" which is at a final draft stage (National Department of Health, 2012). This extensive operational guideline results from a consultative process, initially documented in Sheibe, Brown et al.

(2011) and from input from an extensive network of local and international contributors and reviewers. The guidelines focus on men who have sex with men (MSM), sex workers, people who inject drugs (PWID) and other drug users, transgender people, migrants and mobile populations and detained people and are intended to assist health planners to develop and implement programmes that will lead to an achievement of the targets set for Key Populations in the NSP.

The National Department of Health's draft "HIV Prevention Strategy for the Health Sector" is a practical tool to assist healthcare managers, particularly at a district level to plan and implement prevention interventions in a manner tailored to the needs of all people in their area of work (National Department of Health, 2013). It includes recommendations for MSM services and interventions, which are aligned with the Key Populations policy.

The *"Quality Assurance Standards for Peer Education and Outreach Programmes for High Risk Vulnerable Populations in South Africa (Draft)"* lays out quality assurance (QA) standards for peer education and outreach programmes for men who have sex with men (MSM), sex workers (SWs), and people who inject drugs (PWID) in South Africa (ICF International, 2012). The QA standards are intended to provide guidance to organisations implementing peer education and outreach programmes for MSM, and other key populations in South Africa. The quality of peer education and outreach programmes targeting MSM and other key populations in South Africa is critical to implementing effective intervention agreed quality assurance standards for peer education and outreach programmes are needed to ensure successful delivery of high-quality programmes. The standards and guidelines were developed by a team lead by the Programme for Appropriate Technologies in Health (PATH), Joint Commission International (JCI), and CDC; and were field tested by a range of South African NGOs working with key populations.

INTERNATIONAL ORGANISATIONS POLICIES AND GUIDELINES

A final aspect of the environment in which MSM and key population interventions operate is the guidelines and policies of the various United Nations organisations, including the World Health Organisation and UNAIDS. These organisations have published a range of resources focusing on HIV prevention, treatment and care for MSM and other key populations. These include both broad outlines of necessary changes in support of HIV prevention, treatment and care, such as the "UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People" (UNAIDS, 2009), guidelines for monitoring and evaluation (UNAIDS, 2013) and specific guidelines focusing on the prevention and treatment of HIV and STIs among MSM and transgender people (World Health Organisation, 2011). These WHO-published guidelines are intended to enhance the ability of countries to provide comprehensive HIV responses to MSM and transgender (TG)

populations, and comprise a thorough set of technical recommendations for STI and HIV treatment among MSM and TG populations. The document provides six "good practice recommendations," focused on the following: (1) prevention of sexual transmission; (2) HIV testing and counselling; (3) IEC; (4) HIV prevention focused on substance use; (5) MSM and TG people living with HIV; and (6) prevention and treatment of STIs. It is geared toward national public health officials, nongovernmental organizations (NGOs), and health workers.

The WHO has also published guidelines focusing on STI and HIV treatment for sex workers (World Health Organisation, 2012). Finally, South Africa is a signatory to a 2011 United Nations General Assembly Resolution on "Intensifying Our Efforts to Eliminate HIV and AIDS", which recognises the need to target services at populations at higher risk of infection (United Nations, 2011).

POLICY CONCLUSION

There is clearly a broadly supportive policy environment for the implementation of MSM and key population focused HIV interventions in South Africa. Although there remains a lack of provincial and local government level policy and guidelines for this work, the inclusion of MSM and key populations in the NSP provides a clear basis for this work. There is also a strong recognition of the need for a focus on these populations among the major HIV/AIDS donor organisations, the World Health Organisation and various UN agencies.

PART 3:
CURRENT MSM RELATED HIV PREVENTION AND TREATMENT PROGRAMMES, GAPS AND OPPORTUNITIES

CURRENT PREVENTION PROGRAMMES

Several organisations across South Africa are currently running MSM-related HIV prevention programmes. The main organisations running these programmes are: the Anova Health Institute's Health4Men programme, ICAP's MOSAIC project, the Desmond Tutu HIV Foundation, OUT-LGBT Wellbeing, and Triangle Project. Given the general lack of MSM-specific HIV programmes in South Africa, the interventions that have been implemented to date have been fairly broadly focused on HIV risk behaviours, and the provision of MSM-relevant information and resources.

As such, current HIV prevention programmes for MSM in South Africa include:

- HIV counselling and testing,
- STI testing and treatment,
- condom and water based lubricant distribution,
- provision of information, education, and communication (IEC) resources,
- prevention messaging, and
- community outreach.

There is limited access to medical HIV prevention such as Post-Exposure Prophylaxis (PEP). Several organisations have also implemented health care worker sensitisation training as a means of making health care more widely accessible to MSM in South Africa.

These various prevention strategies, and the extent to which they have been implemented in South Africa to date are discussed below.

RESEARCH INTO ACCEPTABILITY OF AND NEEDS FOR PREVENTION PROGRAMME DESIGN

Prevention messaging forms an important component of HIV prevention programmes worldwide. However, in South Africa, HIV prevention programmes have neglected men who have sex with men (MSM) and there is a lack of research focusing on the prevention information needs of MSM in the country. Anova's Health4Men programme has conducted research focused on understanding the HIV prevention messaging preferences MSM.

Participants in this research identified a clear need for messaging targeting MSM, but when asked to rank various HIV prevention posters, they tended to prefer those that were not identifiable as focusing on MSM. This contradictory preference was directly related by participants to the homophobic social and cultural contexts in which they live. The primary concern identified was the possibility of a violent backlash against MSM if explicitly homosexual messaging was placed in their communities. Other important concerns included: that linking HIV to MSM in messaging would reinforce stereotypical ideas about MSM as being transmitters of HIV; that messaging would reinforce stereotypes of MSM as being only interested in sex; and that messaging would promote ideas about MSM as having more money than other community members.

These concerns have important implications for the design and implementation of HIV prevention messaging for MSM in this context, and raise the possibility of using HIV prevention messaging creatively to address issues around homoprejudice, discrimination and stigma as a means of indirectly increasing MSM's health seeking behaviours.

PREVENTION WITH HIV POSITIVE MSM

HIV prevention interventions that specifically focus on HIV positive MSM play an important role in decreasing HIV transmission rates. The most widely publicised of these types of interventions currently is the use of ART in HIV serodiscordant couples. However, current ART guidelines in South Africa preclude the use of this method prior to individuals CD4 cell counts dropping below 350/mm^3. While current HIV prevention messaging is relevant to the needs of both HIV positive and negative MSM, there is a lack of information available that deals specifically with HIV positive MSM's needs. For example, there is no widely available prevention information discussing the pros and cons of various sero-adaptive behaviours. The need for such information was highlighted in the results of Health4Men's annual online survey (2012), which revealed that MSM in South Africa are adapting their sexual behaviours based on their HIV status, but that fairly high percentages of these men lack accurate information about the relative risks of these various behavioural adaptations (Jobson, 2013a).

PREVENTION AND PLEASURE INTERVENTIONS

The role of sexual pleasure in HIV prevention interventions is often acknowledged, but simultaneously, specific components focusing on sexual pleasure are very rarely included in these interventions. In part, this reticence may be attributed to social and cultural taboos around the discussion of sexual intimacy (Boyce et al., 2007, Lambert and Wood, 2005). Equally, the donors funding HIV prevention programming

may be fearful of creating perceptions that they are promoting sexual promiscuity in the guise of HIV prevention. As such, much of the prevention work that has been implemented in South Africa still centres on the Abstain, Be faithful, use Condoms (ABC) model, despite the limited evidence for its effectiveness.

Interventions focusing on sexual pleasure have been shown to be effective in changing risk behaviours in Southern Africa. For example, Philpott et al. (2006) report that an intervention in Mozambique successfully reduced married men's extramarital partnerships through creating open dialogues about sexual pleasure between marital partners.

There are very few examples of pleasure based prevention interventions for MSM, but Hazra (2006), based on work with MSM in India, argues that approaches to HIV prevention for MSM that emphasise sensuality and mutual pleasure may play an important role in reducing HIV risk in contexts where sexual encounters between men are marked by sexual aggression, and where social ideals about dominance and submission affect men's expectations in terms of their sexual experiences. For example, in some contexts penetrative partners may be expected to behave aggressively or to dominate their partners, which may increase the risk of damage to their partners' anuses and hence increase the risk of HIV infection (Hazra, 2006). This type of dynamic has been noted in some research with MSM in South Africa, with receptive partners emphasising the need to be submissive during sex, and even expressing the desire for, or expectation of, pain as part of anal intercourse. As this participant in a Health4Men focus group discussion states:

> "*It's supposed to be painful, there's nothing helping the penis to get in, so it's supposed to be painful*".

In contexts where sex between men is stigmatised, a focus on pleasure in HIV prevention can also play an important role in affirming the validity of individuals' same-sex desires and in so doing help them to deal with the negative effects of discrimination and internalised stigma.

GAPS AND OPPORTUNITIES FOR HIV PREVENTION INTERVENTIONS

There are several gaps in current HIV prevention programmes for MSM in South Africa. As noted above, the prevention programmes currently in place are focused on: HIV counselling and testing, STI testing and treatment, condom and water based lubricant distribution, provision of information, education, and communication (IEC) resources, prevention messaging, and community outreach. These approaches are in close alignment with PEPFAR's technical guidance on combination HIV prevention for MSM (PEPFAR, 2011) and the DOH prevention guidelines (National Department of Health, 2012). However, these approaches remain firmly within the broad scope of the generic interventions used in tackling the HIV epidemic as a whole, and thus

may not reach MSM with more specific HIV risks resulting from their particular life circumstances, social contexts, or sexual behaviours. Gaps in HIV prevention programming therefore exist in targeting these particularly high-risk individuals and behaviours, and in doing so it may be possible to act synergistically to decrease HIV transmission within the MSM population as a whole.

YOUNG MSM

There are no HIV prevention programmes that focus specifically on young MSM (YMSM) in South Africa. This is an important gap because YMSM experience a range of challenges that are unique to their life stage.

HIV prevention interventions for YMSM could focus on:

- Supporting them in dealing with accepting their sexuality as a normal part of the range of human sexual desires.
- Providing sex-positive sexuality education about male-male sexual practices and risk reduction.
- Sensitising health care and social workers to the particular needs and challenges facing YMSM
- Harm reduction approaches focusing on alcohol and drug use in the context of sexual interactions

OLDER MSM

The particular HIV risks facing older MSM in South Africa have not been addressed in HIV prevention interventions to date.

This gap in HIV prevention programming could focus on several areas, including:

- Sex-positive messaging around aging and sexuality
- IEC materials or harm reduction focusing on drug use, sexual risk, and the use of erectile dysfunction medication
- Encouraging more frequent HIV testing, STI screening and linkage to care

MSM IN RELATIONSHIPS

The relationship context provides an effective basis for HIV prevention interventions, but there are no such interventions currently being implemented in South Africa. As noted in the literature review, the couples context may be particularly risky for HIV transmission among MSM in South Africa.

There is a range of potential interventions that could target MSM in relationships, including:

- Couples based voluntary counselling and testing
- Couples specific IEC materials focusing on discussing sexual risk and sexuality within relationships
- Access to information about sero-discordancy, sero-adaptive behaviours, and ART as prevention in sero-discordant couples.

MSM SEX WORKERS AND TRANSACTIONAL SEX

While there are HIV prevention interventions in existence that focus on MSM sex workers, these are limited to the major metropolitan areas and focus specifically on individuals whose primary occupation is sex work. There are gaps for interventions focusing on intermittent sex work, and transactional sex in the contexts of MSM's everyday lives. There is a particular need for a focus on HIV prevention with straight identifying MSM ("after nines").

Possible interventions could include:

- IEC materials, condoms and water based lubricant distribution in the venues in which transactional sex and sex work occurs.
- Increased MSM sex worker focused HCT and STI screening
- Health care worker sensitisation training or development of manuals focusing on the particular needs of MSM sex workers.
- Prevention interventions focusing on transactional sex and alcohol use
- Interventions aimed at improving self-esteem and self-efficacy among MSM who 'pay' for sex in the contexts of alcohol use.

MSM DRUG USERS

In spite of drug use being well documented among MSM in South Africa there remain very few programmes that target this aspect of HIV risk. There are a range of possible interventions that could be developed to target drug-using MSM in the country.

These include:

- A specific focus on drug use in the context of sex parties, group sex, and sex on site venues
- Non-judgemental IEC materials focusing on risk reduction when using drugs

- Information about the risks of combining different substances (such as poppers and erectile dysfunction drugs)
- The development of MSM-specific drug use risk reduction counselling training for health workers and people working with drug users.

MSM AND STRUCTURAL ISSUES

The range of structural issues affecting HIV transmission among MSM in South Africa have not been addressed by any HIV prevention programmes to date, outside of research evaluations. There is a need for these issues to be addressed in order to work towards creating more supportive environments and local contexts for MSM.

HIV prevention programmes focusing on structural issues could therefore include:

- Anti-homophobia messaging and interventions at health care services, police stations and other government departments
- Work with religious leaders to address homophobic beliefs in their communities and congregations
- Work with cultural authorities and traditional leaders around historical precedents of cultural acceptance of same sex sexualities
- Work with educational institutions towards reducing homophobic discrimination and violence.

HIV CARE AND TREATMENT FOR MSM

CURRENT TREATMENT PROGRAMMES

Until 2009, no medical services specifically targeting MSM for sexual health and HIV care were available in South Africa. This situation existed despite inclusion of MSM-targeted health services in the country's previous National Strategic Plan for Health Care. Gay men and other MSM received care at regular state-sector HIV clinics, which were not capacitated to provide appropriate, MSM targeted-services. Health provider stigma acted as a barrier to health access by MSM as clinics were not sensitized or competent to address their health requirements (Lane et al., 2008b, Muraguri et al., 2012, , Rebe et al., 2010, Rebe et al., 2013b, Rebe et al., 2012, Rebe et al., 2011b,).

In 2009, the Anova Health Institute launched the first MSM-targeted HIV and Sexual Health and Wellness service in Cape Town. This service (Health4Men) was initially

developed and run in partnership with the Western Cape Department of Health and was supported and funded by PEPFAR/USAID. The programme was extended to Soweto in 2010. The design of this program has resulted in the creation of two Centres of Excellence (COEs), which facilitate the development and testing of MSM health guidelines. Operational research also occurs at the COEs and is aimed at improving the package of care for local MSM, for example, knowledge gained via implementation of MSM services at the COEs has been used to develop training and mentoring programs, aimed at institutionalizing and mainstreaming appropriate MSM healthcare in existing state-sector STI and HIV/ART clinics. In addition to the COEs, MSM healthcare-trained and competent clinics within this model now exist in five provinces.

During the past three years, other strategic partners have contributed significantly to the development and institutionalization of MSM health services into state healthcare programs. These partners include: The Desmond Tutu HIV Foundation, ICAP, OUT-LGBT Wellbeing, FPD, Right to Care, NACOSA and others. The Anova Health Institute, via its Health4men clinics, remains the largest provider and supporter of state-sector, primary level, MSM health services with care provided to more than 10 000 MSM to date. Health4men operates or supports clinics in Johannesburg, Soweto, Cape Town, Khayelitsha, Nelspruit, Ermelo and Tzaneen.

The scope of practice at Health4men sites includes:

- HIV: Screening, wellness, treatment and support and prevention
- STI: Screening, treatment, prevention and surveillance
- Mental Health: Life skills, adherence support, couples counselling and linkage to care with psychology, psychiatric and harm reduction services
- Harm reduction and other services for MSM who use drugs (AidsFonds funded) or are involved in commercial or transactional sex work or who are displaced refugees

Programme activities both on and off-site include:

- Training and mentoring of health care workers
- Provision of a variety of condoms and sexual lubricants
- Community support and education projects
- Health communication projects (IEC and other materials)
- mHealth support via the H4M.mobi and Health4Men websites
- Peer educator and community Ambassador projects
- Technical support to state-sector clinics providing care for MSM
- Biomedical and psychosocial operations and implementation science research

SUPPORT FOR MSM TARGETED PROGRAMMING

The past two years have seen an expansion in support for MSM targeted programming in South Africa, in particular from PEPFAR, accompanied by high level government support. The Anova Health Institute's Health4Men programme is PEPFAR/USAID funded and works in five provinces to develop MSM competent state sector facilities and to provide treatment and prevention information. In addition, a Global Fund sub award is currently in negotiation between Anova and Right to Care to extend MSM competency training to the remaining four provinces. The PEPFAR/CDC funded ICAP Mosaic programme works in five provinces to support HIV prevention in partnership with local groups and to sensitise health workers. There is little support for treatment-targeted support in the private health sector.

A number of civil society organisations are active in HIV prevention and human rights advocacy. Donor support for prevention initiatives, in general, is considerably less than that available for treatment initiatives.

SERVICE GAPS AND PROGRAM OPPORTUNITIES

There is currently a concern with the translation of evidence-based knowledge about MSM health care provision into operationalized programs in Africa. This includes both a failure to scale up existing treatment and prevention interventions (e.g. hepatitis B and C screening / vaccination) and to implement new technologies such as PrEP and early ART treatment for prevention (TasP). While HIV treatment is similar in MSM and MSW, there are some specific treatment issues that are not well addressed by mainstream clinics.

Additionally, sexually transmitted infections in MSM patients are often poorly or inadequately managed. Structural contributors to inadequate management include in-country guidance for the empiric treatment of STIs, which do not address the needs of MSM, and nurses and doctors who have not received competency training to address these needs. (South African Department of Health, 2003)

Current treatment gaps and opportunities will therefore be considered under the following headings:

a) HIV and ART
b) Sexually transmitted infections

HIV AND ART

Opportunity: Implement a program of early ART initiation for MSM and monitor adherence, retention and health outcomes.

Early treatment with antiretrovirals has been shown to decrease HIV transmission among discordant heterosexual couples (Cohen et al., 2011). Similar evidence is lacking for MSM but ecological evidence supports similar risk reductions when using early ART in MSM (Das et al., 2010, Cowan et al., 2012). Individuals who are HIV positive are likely to benefit from earlier treatment and have improved health outcomes. The WHO has recently revised its ART recommendations to initiate individuals on ART if their CD4 count is below 500 copies/mm^3. South Africa currently recommends later treatment, however, treating earlier with ART would provide both individual and community level benefits (Baggaley et al., 2010). Early treatment might also improve retention in care since a large percentage of loss to follow up of MSM occurs between HIV screening and initiation of ART – the "wellness group" who are currently receiving little health programing aside from 6 monthly CD4 count estimations.

Opportunity: Implement point of care ART monitoring and measure effect on adherence, retention in care, quality of life, health preferences and health outcomes.

Attracting MSM into sexual health services may be difficult due to fear of health provider stigma. (De Swardt and Rebe, 2010a) Similarly, retention in care may also be challenging. The effect of point of care monitoring of patients pre- and on-ART using point of care CD4 and viral load monitoring technology has not been investigated in local MSM and could provide potential benefits.

Opportunity: Develop alternative ART collection depots at non-medical, shop front-style sites close to where MSM live or congregate.

Since MSM are often suspicious of the health care sector, alternative models of ART provision and collection might improve adherence and health outcomes. Health4men promotes a program of sexual wellness; HIV positive MSM who are stable and have no current health challenges do not necessarily need to be attended to in a hospital or clinic. Alternative "shop front"-style drop-in ART collection depots (such as the Magnet Model in San Francisco) are not currently available. Such services could benefit both individuals accessing treatment and the state-healthcare system, which could be decongested of well patients who attend simply to pick up medications. Similar alternative distribution strategies are already

being implemented for wider ART delivery in some areas of South Africa. This approach may provide opportunities to extend HIV prevention messaging, and HCT, in addition to and ART delivery for MSM in acceptable community centres. This programme would need to include measures of impact on adherence, retention in care, quality of life, health preferences and health outcomes.

Opportunity: Develop appropriate adherence support strategies for MSM, utilising web based and social media technologies.

Antiretroviral treatment adherence is a challenge in all settings, and may particularly be so given the many other issues, including stigma and high levels of drug use, that exist in the MSM community. Overburdened state sector antiretroviral services have little resources to promote adherence or address the individual needs of MSM. The use of web based or mobile phone based adherence support services have been shown to be successful in other settings and can allow for confidential and individualised support. There is a need to develop, or possible collaborate with and adapt existing examples of these for South African MSM.

Opportunity: Broaden the menu of ART agents available to construct suppressive HIV regimens that are individually tailored to MSM patient needs and concerns.

The South African Department of Health mandates the use of specified first and second line ART regimens (i.e. tenofovir, emtricitabine and efavirenz in first line and zidovudine, lamivudine and lopinavir/ritonavir in second line). These medications may not be entirely suitable for MSM and it is problematic that alternative, more individualized ART medications are not proposed. An example includes the use of lopinavir/ritonavir in second line treatment. This agent commonly causes flatulence and diarrhoea, which are troubling for all individuals but may also result in sexual dysfunction for MSM engaging in receptive anal sex. Widespread use of psychoactive ARVs such as efavirenz may also negatively impact on the health of MSM who have a higher rate of mental health diseases than their heterosexual peers and who use recreational drugs which might result in drug-drug interactions. As a research question, there would be value in investigating the effects of alternative ART agents such as ritonavir-boosted atazanavir and integrase inhibitors on MSM health outcomes and quality of life.

Opportunity: Implement and monitor a PrEP pilot project for MSM attending MSM Competent Services.

Evidence for the use of antiretrovirals as prevention for HIV negative MSM was provided by the Global iPrEx study with further evidence expected from iPrEx OLE (open label extension) and other demonstration pilot projects. (Grant et al., 2010) Local guidelines for the safe use of PrEP in MSM have been developed and published. (Southern African HIV Clinicians Society, 2012) Despite this, PrEP is not available in state-sector facilities.

The NSP provides for introductory work to implement and deliver PrEP and other novel prevention technologies. At present little is known about the willingness of South African men to use PrEP, or what the most effective delivery systems would be. The availability of MSM targeted services, in specialised sites, research sites and in primary health care, provides an opportunity to move into a pilot programme of PrEP delivery.

Opportunity: Develop and implement training and materials to up-skill emergency room staff and private practitioners in the provision of PEP for key populations.

Post exposure prophylaxis (PEP) is advocated for the prevention of HIV transmission to negative individuals following potential exposure. (SA HIV Clinicians Society, 2008, WHO, 2007) PEP has traditionally been used in South Africa following needle-stick injuries and after sexual assault but not following risky consensual sex. Many health care workers in the state health sector are unaware of this additional indication. Several NGO's, in particular Health4Men and OUT LGBT Wellbeing, have promoted community awareness of PEP through IEC materials, community outreach, web and media campaigns. Despite this, there is little uptake of PEP and few facilities are capacitated to provide PEP. Embarking on a course of PEP is often difficult for MSM for the following reasons:

- It is often required outside of expert-HIV clinic operating hours and thus needs to be accessed via busy emergency units
- Emergency room staff are often untrained in counselling MSM for HIV screening, which is required before starting the drugs
- MSM fear health provider stigma and loss of confidentiality regarding their sexual orientation and HIV status

There is a need to develop, or adapt, and implement training materials and information resources to make PEP more widely offered and available.

Opportunity: Pilot and monitor the provision of PEP "starter packs" to MSM who are HIV negative and are in regular care at MSM competent clinics.

A complementary approach to PEP provision is to provide MSM who have recently tested HIV negative with PEP "starter packs", which they could start in the event of a

high-risk exposure to HIV. With appropriate guidance this would enable MSM to rapidly initiate PEP after a risk incident prior to consulting a medical practitioner. Such a programme would need careful implementation and monitoring, but could be beneficial in reducing HIV infection rates by removing some of the barriers to accessing PEP for MSM.

SEXUALLY TRANSMITTED INFECTIONS

Opportunity: Improve health access to HIV services by MSM by leveraging STI-targeted health communication messages, mHealth and venue based campaigns. Monitor the effect on HCT screening and retention in care.

Sexually transmitted infections (STIs) are common among MSM and are increasing even in countries where HIV rates are stable or decreasing; this speaks of on-going high risk sexual behaviours in this population group.(Cowan et al., 2012) STIs act as an entry point into care as MSM may be avoiding health care services due to fear of HIV-status-based stigma.

Opportunity: Strengthen partnerships with the National Institute of Communicable Diseases and the country's GERMS Surveillance program to collect and process STI specimens collected from MSM at collaborating clinics.

A major challenge in South Africa is that the current Department of Health guidelines for the empiric treatment of STIs do not cater for the needs of MSM. Specifically, a high percentage (and often the majority) of gonorrhoea and chlamydial infections in MSM are asymptomatic. They would thus not be detected or treated using current in-country heteronormative STI guidance. (Lewis et al., 2013). A second major challenge is that poly-drug resistant gonococcus (and specifically cefixime and ceftriaxone resistant strains) is more common among MSM. Two isolates of cefixime resistant cases have been detected in Johannesburg and another via the Health4men clinic in Cape Town. (Lewis et al., 2013).

Current in-country guidelines preclude isolation of the offending STI organism and antibiotic sensitivity estimation. As clinical STI specimens are not collected in the state sector, no such specimens are processed by the National Health Laboratory Service and antibiotic surveillance is not occurring. This is extremely problematic and needs to be urgently addressed as systematic under-treatment of MSM may be occurring which could drive further gonoccocal resistance. This opportunity would provide an evidence base for improving the applicability of current STI guidelines to MSM and would inform the Department of Health of the need to update or change these guidelines.

Opportunity: To broaden STI screening of healthy MSM without STI symptoms to detect and treat asymptomatic disease (ASTIs).

This would have multiple possible benefits including; maintaining genital mucosal health which may positivity affect HIV incidence, providing an access point and a retention mechanism for healthy MSM who would not otherwise attend services for HIV risk reduction, lowering the morbidity associated with STIs and allowing for the development of cost-effective screening algorithms.

Opportunity: Point of care screening for STIs

The technology has recently become available to screen MSM for symptomatic and asymptomatic STIs using point of care technology (GeneXpert CT/NG and HPV, Cepheid) and syphilis (Syphilis Rapid, Alere Medical). STI screening could be routinized for MSM, raising awareness of this health issue, improving attendance at health facilities, improving general HIV prevention and health knowledge and engagement and of course providing an opportunity to treat infections and prevent them from becoming symptomatic. All of this could be done in a single clinic visit, thus ensuring correct diagnosis and treatment occurs without loss to follow up. An evaluation of the effectiveness of such an approach is needed.

Opportunity: Explore the feasibility of implementing an anal pre-cancer screening program for MSM.

Anal HPV infection is associated with an increased risk of anal cancer (similar to the elevated risk of cervical cancer in HPV infected women). (Jong et al., 2011) Currently there are no anal Pap smear services in the state sector. Also, Gardasil HPV vaccination is not available for MSM in South Africa outside of the private sector. By monitoring service utilization rates, HPV detection rates and rates of intra-epithelial anal neoplasms (AIN), a facilitated referral pathway could be developed to refer clients with AIN to curative services at tertiary state-hospital Ano-rectal surgery departments.

The provision of Gardasil vaccination to young MSM and to older MSM who have not had clinical genital warts would also play an important role in decreasing the incidence of HPV and hence of AIN.

Opportunity: Expand viral hepatitis screening for all MSM attending HIV and STI services and vaccinate hepatitis A and B susceptible individuals.

Community knowledge of the risks of hepatitis remain low and this project would provide an opportunity to educate gay and other MSM about this risk and allow them to mitigate it. Viral hepatitis is common among MSM because hepatitis A and B can be sexually spread during same-sex activities. Hepatitis A vaccination is not included in South Africa's paediatric vaccination schedule. Hepatitis B vaccination is currently included but there have been no catch up campaigns for sexually active MSM who have not previously been vaccinated and remain susceptible. Hepatitis B vaccine is included in the country's essential drug list and thus should be available at primary health care centres but this is often not the case. Our experience during the past four years is that primary care pharmacies often do not order or stock this vaccine, limiting availability.

Opportunity: Screen all MSM attending sentinel MSM sites for hepatitis C in order to investigate factors associated with positivity.

Hepatitis C is common in populations of people who use drugs, especially where the route of drug use is intravenous. Hepatitis C is also transmitted sexually between MSM. Currently no routine screening for hepatitis C in high risk MSM is available. Screening all MSM attending sentinel sites, such as the Health4Men clinics, for hepatitis C would allow for the development of a cost effective, locally evidence-based screening algorithm that could be utilized by the Department of Health.

PART 4:
MSM PROGRAMMING IN SOUTH AFRICA: KEY STAKEHOLDERS VIEWS

A. INTRODUCTION AND METHODOLOGY

Singizi Consulting was commissioned to work with the Anova Health Institute to undertake a rapid review of existing and planned programming for HIV prevention, testing, counselling and treatment and care services; and a review of perceptions of MSM programming needs, gaps and priorities in terms of this.

Data were collected through telephonic interviews with respondents from the National and Provincial Departments of Health, bodies such as SANAC, NGOs, PEPFAR partners, international agencies and selected private medical practitioners. A list for this assessment was developed from contact lists, meeting participants and major agencies of 60 identified respondents from 49 institutions, and interviews were completed for all available participants against this list between the 2nd and 23rd of September, 2013. A total of 40 respondents were interviewed from 35 institutions. Respondents included representatives from SANAC and the national Department of Health, eight of the nine provincial health departments and a wide range of non-governmental and donor organisations. Two respondents declined to participate, whilst the others were not available for interview during the period, or another representative of the organisation had already responded.

While efforts were made to ensure broad representation, the rapid assessment methodology may not have allowed for full participation by all relevant groups. Respondents were informed that the data collection was in order to provide information on priority funding areas for an unidentified funder, to avoid any bias in this regard. Conversely, this may have limited the information that participants were willing to share.

The purpose of the assessment is to provide a better understanding of responses to HIV for MSM populations, both by the government and non-governmental sectors, and to identify areas of need for enhanced programming.

The rapid assessment has been completed in the context of an increase in interest in MSM programming in South Africa and in the region, partly due to major funders such as the Global Fund and PEPFAR advocating for funding for this. This assessment happens at a time when some of these processes are still being planned for but, at this point, MSM HIV prevention, treatment and care programming appears to remain minimal, and is regularly undertaken by NGO or community groups, and not taken to scale in the country.

This report provides a description of the programmes and services currently made available to MSM, and also explores the extent to which research is being conducted in terms of the prevalence and incidence of MSM with HIV. The report also reviews perceptions of key role-players in terms of key gaps, areas of opportunity, and current priorities.

The report is structured as follows:

Section A :	provides an introduction and the methodology employed for this component of the rapid assessment;
Section B	considers the extent to which governmental and non-governmental organisations have developed any specific policies or guidelines for MSM, outside of the National Skills Plan (NSP) and the Operational Guidelines for Key Populations currently being finalised;
Section C	describes and documents the key programmes and services available for MSM, both at the level of government and at the level of the non-governmental sectors;
Section D	reports on research studies being conducted on MSM and the nature of these, in accordance with the information provided by respondents;
Section E	reviews perceptions of current gaps, opportunities and priorities in MSM programming and service provision; and
Section F	provides an overarching summary of the findings emerging from this assessment.

4. A METHODOLOGY

A set of instruments was developed for the purposes of the telephonic interviews which probed, as relevant, the following areas:

- MSM-related policies and guidelines: this probed the extent to which policy and guidelines exist (both those developed by the South African Government, as well as organisation-level policies and guidelines), the extent to which respondents were aware of these, and perceptions of the comprehensiveness and relevance of these;

- Nature of MSM Programming and Services: this involved the collection of interview data on current programming and current service provision in terms of MSM. This includes data collection on the types of programmes and services currently in existence, as well as planned for the future, the reach in terms of these programmes and services (including their location geographically), and the different types of providers involved in areas of provision.
- Partnerships in MSM provision: respondents were also asked to indicate the extent to which they collaborated with partners in the implementation of programmes and delivery of services, and the nature of these partnerships;
- Research in MSM: respondents were asked to indicate whether or not their organisations were directly involved in the development of any research on MSM and HIV, and the nature and status of this research. This included a consideration of any research pertaining to incidence and prevalence of HIV in MSM populations;
- Gaps, Opportunities and Priorities: finally, respondents were invited to share their views on the most significant gaps and opportunities in MSM programming and service provision, and to consider the most important priorities for programming and provision if funding were available for these purposes.

Singizi also requested interviewees to make available any grey literature on MSM that they would feel comfortable contributing to the desktop review component of this study. However, most respondents reported not possessing any literature of this nature. The few documents that were made available have been provided to the desktop reviewer.

In line with the requirements that the potential donor organisation for this assessment remain anonymous, respondents were asked to participate in the assessment on this basis. While the vast majority of respondents agreed to participate accordingly, a small number chose not to participate in the assessment without further detail on the potential donor. Where this was the case, the team has used online and publically available resources, as well as references made to specific programmes by other interviewees, to augment some of the gaps in this regard.

4. B: MSM POLICIES AND GUIDELINES

This section reviews the extent to which respondents indicated knowledge of MSM-related policies and guidelines, or were in possession of guidelines that may have been developed at the level of the organisation.

GOVERNMENT RESPONDENTS

Respondents from the National Department of Health (NDoH) referenced the Department of Health's draft *Operational Guidelines for HIV, STIs and TB Programmes for Key Populations* (November 2012) as the key government resource document for MSM (as well as other "key populations", including sex workers and intravenous drug users or IDUs) in South Africa. Both respondents from the NDoH indicated that the Operational Guidelines have emerged from the National Strategic Plan (NSP) on HIV, STIs and TB, 2012-2016 and that the Guidelines are an attempt to "standardise" the NSP for key populations. The respondents indicated further that a national Prevention Strategy is also in the process of being developed, and that this will link to the Operational Guidelines.

While still in draft form, the NDoH indicated that there had been "*wide consultation*" on the Operational Guidelines, and that the document is currently being circulated for further input prior to finalisation.

Most Provincial Department of Health respondents were all aware that the national Operational Guidelines were being drafted, and none reported to have any other provincial guidelines or policies in place with regards to MSM in particular. A respondent from Gauteng commented that the province would "*rely on national to finalise the guidelines, and then we will adapt them to suit our own programmes*". A respondent from the North West Provincial Department of Health welcomed the finalisation of the Operational Guidelines, and indicated that the government had not made sufficient progress to date in mainstreaming key populations. The respondent indicated that it was the "*commitment of government to attend to those issues – key populations – we are trying to focus on those things and orientate our professionals on how to deal with their clients. If a client has an STI, we mustn't exclude them or make assumptions. These are human rights issues*".

Eastern Cape and KwaZulu Natal DoH respondents did not appear to be aware of the Operational Guidelines, and both indicated that the NSP guided their policy on provision to MSM. One respondent indicated: "*we don't have specific policies. If they (MSM) come to us for treatment, they get the treatment*". The respondent from KwaZulu Natal indicated that while the NSP guides implementation, specific policies for MSM were required, and would be welcomed by the Department. The respondent indicated further that Provincial Departments of Health should be "*influencing*" national government policy, but that – due to issues of stigma associated with MSM in the province – there was "*no organised movement in this*

regard" and, as such, "*no concomitant response to encourage such a policy to be put in place*".

NON-GOVERNMENTAL RESPONDENTS (INCLUDING DONORS AND NGOS)

Non-governmental respondents were generally very positive about the development of the Operational Guidelines, and several respondents reported that the guidelines were both comprehensive and relevant. Comments included:

"*They are good and very comprehensive. In the last couple of years there has been an increasing focus on MSM, with the acknowledgement that it is not just a 'gay' issue, but that the increased prevalence of HIV amongst MSM affects the whole population*"

"*The National Guidelines on key populations…they're good, very comprehensive*"

"*The Guidelines are good. A national strategy does need to happen. There is a need to harmonise legislatively what is happening on a grass roots level*"

However, respondents expressed some concerns about the extent to which the Operational Guidelines would be implemented in the spirit intended. As one respondent commented: "I am worried, though, that people are going to be doing the 'right thing' in implementing the guidelines, but not really internalising what it means to provide services to key populations. They'll just follow the guidelines and not think about how their behaviour or attitude needs to change". The respondent indicated that the need for identifying how issues of stigma could impact on implementation is an area that needs further exploration.

Another respondent indicated concern about the extent to which the Operational Guidelines would filter down to the level of the health district and health facilities in terms of implementation. The respondent commented: "like so many things in this country, it is not the policy, it is the implementation of the policy where there may be a gap". Linked to this, a respondent indicated that international studies on MSM had suggested that MSM "travel for miles to be treated in 'safe' facilities" and that it was possibly unrealistic to anticipate that all facilities could become 'safe' spaces for MSM. It was the view of this respondent that successful implementation of the Operational Guidelines would ultimately be reliant on leadership at the level of individual health facilities, and that this would likely vary.

Respondents were also asked to indicate if they were aware of any other non-governmental guideline documents available for MSM and HIV.

A CDC respondent indicated that for the past few years, the CDC has been involved in developing guidelines and sensitivity training for health care workers. In addition, the CDC has been also working with a number of other organisations to

develop standards for peer educators for key populations. Peer education is seen as a critical part of key populations programmes, and, as reported by the CDC, there has been a very broad range of quality of these educators, and so it is viewed as important to standardise these services. A respondent from PATH indicated that their major work in relation to MSM thus far has been in developing these quality assurance standards for peer educators for key populations. This has involved working with local MSM groups, and has resulted in the development of a Quality Assurance Standards Compendium, which is being finalised, and will be available by December 2013. The respondent indicated that the need for the standards was identified, as there are a lot of different organisations doing peer education, but they were all doing it differently, so organisations have worked together to try and standardise the approach. The work was USAID funded, and peer educators will be trained in the standards.

The Anova Health institute, in turn, has played a pivotal role in adapting Department of Health guidelines related to HIV management into protocols and guidelines specific to MSM sexual health, including the promotion and use of combination prevention modalities. In addition, Anova has contributed to international and World Health Organisation MSM guidelines. An Anova staff member also co-chaired the Southern Africa HIV Clinicians Society PrEP guidelines, described below.

The Southern Africa HIV Clinicians Society has compiled Pre-Exposure Prophylaxis (PrEP) guidelines for MSM. These are published in the Southern African Journal of HIV Medicine, June 2012, Issue 44, Vol. 13, No. 2, and are available on the Society's Website (www.sahivsoc.org). A SANAC respondent indicated that it was anticipated that PrEP would become a key focus in the new round of Global Fund funding for MSM.

4. C: MSM AND HIV SERVICES AND PROGRAMMES

SUMMARY OF MSM PROGRAMMING AND SERVICES

This section provides a summary of the provision of MSM programming and services. The sections that follow (Sections 6 to 9) provide further detail on programming and services provided by government respondents, non-governmental respondents, private practitioners, as well as respondents from donor agencies, international agencies and umbrella organisations.

GOVERNMENTAL SERVICE PROVISION

The South African Government's (SAG) approach to MSM service provision supports integrated service delivery to all, including MSM and other identified key populations. As such, emphasis is placed on ensuring that healthcare workers and facilities at the coalface of primary health care are equipped to provide MSM with appropriate services. This is to largely be achieved through sensitisation training, as well as concomitant clinical training and mentoring to support MSM and other "key populations".

While interviews with several government respondents emphasised the need for increased sensitisation and related training for healthcare workers, the data emerging in this assessment suggests that there is substantial activity in this regard, both in terms of current training, as well as planned training pertaining to increasing healthcare workers' competence for MSM. The figure below represents the current coverage of this training and mentoring (as reported by respondents in this assessment), which is presently being rolled out by organisations such as the Anova Health Institute and ICAP. Between the two institutions, training is planned in all nine provinces. Anova has been undertaking such institutionalising of MSM competence in Gauteng, Limpopo, Mpumalanga, North West and Western Cape, while ICAP has been working in Eastern Cape, Free State, KwaZulu Natal, Limpopo and Northern Cape provinces.

In addition, A Right to Care respondent confirmed that the Global Fund to Fight Aids, Tuberculosis and Malaria (GTAFM) in South Africa is supporting further MSM competent health services (through sensitisation, training and clinical mentoring) in the Free State, Eastern Cape, Northern Cape and KwaZulu Natal to facilitate national coverage. This will involve 59 existing health facilities in these provinces becoming both MSM and WSW competent. This grant has been awarded to Anova, allowing for a national comprehensive and coordinated response to HIV among MSM.

NON-GOVERNMENTAL SERVICE PROVISION

Service provision has tended to be concentrated in Johannesburg and Pretoria, Cape Town and Durban, with isolated scatterings of provision in other areas, primarily through the work of Anova and the ICAP Mosaic initiative. Further, the geographic summary indicates that the largest portion of programming is in combination prevention and HCT, with only seven centres countrywide providing holistic services for MSM, including treatment (six of these are Health4Men initiatives and the remainder is the OUT clinic in Pretoria).

The table below provides further information on the programmes and services for MSM summarised above. The data is represented by province, and specific areas of provision are outlined in more detail per organisation.

A further mapping exercise is in progress, led by CDC south Africa, which aims to identify MSM programming down to a district level.

Table 1: NON-GOVERNMENTAL Service Provision by Province

			Holistic prevention, treatment and care	HIV/ STI/ TB Screening	Capacity Building (NGOs/CBOs)	IEC	HCT	Condom & Lube Distribution	Peer Education	Psychosocial Support
Northern Cape	**Province-wide**	Health4Men/Anova	■			■				
	Kimberley	ICAP			■					
		OUT (Mosaic/ ICAP)								
		Diamond Gays & Lesbians Ass. (Mosaic/ICAP)				■		■	■	■
		Other members of ICAP Mosaic CoP				■	■	■	■	■
KZN	**Province-wide**	Health4Men/Anova	■			■				
		Durban Lesbian & Gay Community Health Centre		■		■		■		
	Durban	ICAP			■					
		Durban Lesbian & Gay Community Health Centre		■				■		
		OUT (Mosaic/ ICAP)								
		Lifeline				■	■		■	■
		Other members of ICAP Mosaic CoP				■	■	■	■	■
	Pietermaritzburg	ICAP			■					
		ICAP Mosaic CoP			■	■	■	■	■	■

			Holistic prevention, treatment and care	HIV/ STI/ TB Screening	Capacity Building (NGOs/CBOs)	IEC	HCT	Condom & Lube Distribution	Peer Education	Psychosocial Support
	Zululand District	SHIPP			■					
E. Cape	**Province-wide**	Health4Men/Anova	■			■				
	Port Elizabeth	ICAP			■					
		ECGLA (ICAP/ Mosaic)					■	■		
		Other members of ICAP Mosaic CoP				■	■	■	■	■
Free State	**Province-wide**	Health4Men/Anova	■			■				
	Bloemfontein	ICAP			■					
		National LGBTI Health Campaign				■	■	■		
		Other members of ICAP Mosaic CoP				■	■	■	■	■
Limpopo	**Province-wide**	Limpopo LGBTI Proudly Out				■	■	■		
	Capricorn District	ICAP			■					
		Limpopo LGBTI Proudly Out & other members of ICAP Mosaic CoP				■	■	■	■	■
	Mopani & Vhembe districts	Health4Men/Anova	■			■		■		
Mpuma-langa	**Gert Sibande District**	SHIPP			■			■		
		Health4Men/Anova	■			■		■		

			Holistic prevention, treatment and care	HIV/ STI/ TB Screening	Capacity Building (NGOs/CBOs)	IEC	HCT	Condom & Lube Distribution	Peer Education	Psychosocial Support
		UCSF/ Project Boithato								
	Ehlanzeni District	Health4Men/Anova								
Gauteng	**Province-wide**	Health4Men/Anova								
	Tshwane	OUT								
		ICAP								
		ICAP Mosaic CoP								
W. Cape	**Cape Metro**	Health4Men/Anova								
	Eden	Health4Men/Anova								
	Winelands	Health4Men/Anova								
		Triangle Project								
		DTHF								

The following sections of the report document and describe programming and services available for MSM in terms of those organisations interviewed for this assessment. The first section outlines government's provision of services and programmes, as well as information pertaining to government's awareness of other interventions taking place within their spheres of governance.

Following sections, in turn, document and describe programmes and services on the part of non-governmental organisations, in terms of the information provided by respondents.

It is noted here that most respondents were not able to provide information on reach of services in the course of the interviews. However, where this was made available in or after the interview process, the data are included here.

GOVERNMENT

This section of the report deals with government services and programmes for MSM, including programmes and services funded directly by the SAG, as well as programmes run by partners in the relevant areas. In many cases, further detail on the programmes and services provided by partners is discussed in more detail in the next section.

This section reviews data from the National Department of Health and eight of the nine Provincial Departments of Health. The Mpumalanga respondent was not available for an interview in the fieldwork timeframe.

NATIONAL DEPARTMENT OF HEALTH

In the course of the interviews, National Department of Health respondents expressed the view that service provision for MSM needs to be viewed in the context of the South African Government's (SAG) position of the provision of integrated services for all. As one respondent commented, "*with the Department, it becomes difficult to talk about specific groups. We encourage everybody who comes in to be treated as an individual. If a person walks in as a man, they are treated as a man, and not an MSM…the service we provide, we provide for everybody. We don't segregate*".

The respondent indicated that while non-governmental options for MSM service provision existed in a scattered fashion across the country, the Department was not in a position to establish separate services for key populations, as these are considered "*costly and not really practical*". Instead, the SAG's thrust is to ensure that the service needs of different populations can be adequately addressed within existing departmental health facilities. As one NDoH respondent commented: "*We are trying to make it for MSM whereby they can access health care from any health care clinic. We are doing that training on those staff that work in the clinics, so that they can deal with them (MSM)*". Another NDoH respondent indicated that the training was focused on appropriate clinical intervention for different populations: *If they (clinical staff) are dealing with a man who identifies as an MSM, for example, for HIV prevention, we need to consider lubrication, and STI we need to consider anal STI as opposed to hetero transmission. But it doesn't make it any difference who you are - if you're MSM or someone else*".

One NDoH respondent indicated that there were a small group of professional nurses who had been trained to deal with MSM cases in

particular, but that there was a need for greater levels of training, as well as training across facilities. It was indicated that the trained professional nurses were currently operating from just a few sites, but that there were plans for this to be expanded with the finalisation of the Operational Guidelines.

NDoH respondents indicated that several international donor agencies in South Africa were supporting both capacity building – including sensitisation and clinical training for DoH staff - as well as direct services provision for MSM and other key populations. These include PEPFAR, USAID, CDC, the Global Fund (GF) and, inter alia, the International Organisation for Migration.

PROVINCIAL DEPARTMENTS OF HEALTH

EASTERN CAPE DEPARTMENT OF HEALTH

The respondent from the Eastern Cape Provincial Government indicated that apart from the provision of integrated services, the Department had "*no plans to roll out other MSM services in the Department*". The respondent commented, however, that the Operational Guidelines might prompt changes in this regard when they are completed.

In terms of partnerships, the respondent indicated that ICAP and Mosaic (ICAP's community of service programme described in more detail in Section 7) worked "*hand in hand*" with the Department to provide services for MSM, and that ICAP was also focusing on training Departmental healthcare workers on "*how to deal with MSM when they present at the clinic*".

Finally, the respondent indicated that there were other small organisations within the Province that dealt with MSM and health issues, but he was not aware of the detail of their contributions.

FREE STATE PROVINCIAL DEPARTMENT OF HEALTH

The respondent from the Free State Provincial Department of Health indicated that HIV services for MSM were integrated into general services available. The respondent also indicated that the Department was awaiting lubricant supplies from the National Department of Health.

The respondent indicated an NGO called the National LGBTI Health Campaign was the key organisation dealing with MSM issues in the Province, and that their work primarily focused on peer education programmes for LGBTI populations, awareness raising at the level of the community, condom

distribution, pamphlet distribution, and related. It was indicated that the NGO used to be funded directly by the National Department of Health, but that this funding ceased two years ago, whereupon the organisation approached the Provincial Department of Health. The respondent indicated that "*we are trying to get them funds, but this has not happened yet*", although the organisation reportedly still operates in the Province and works with its Community Health Education Programme (more detail is provided on the National Health Campaign in section 7).

The respondent indicated that ICAP was also working within the province, but the respondent indicated that "*they are not working with us*" and did not have additional information on their activities. The respondent from ICAP, however, indicated that they were providing sensitisation training for government facility staff in the province (presently in and around Bloemfontein).

GAUTENG DEPARTMENT OF HEALTH

Respondents from the Gauteng Department of Health indicated that MSM are treated routinely at government health facilities that deal with STIs, HIV and TB, in alignment with the integrated approach to service provision. The Anova Health Institute's Health4men programme operates collaborative services at three clinic sites in Johannesburg and Soweto. One respondent indicated that the Province is proceeding with the rollout of sensitisation training pertaining to MSM, through the Anova Health Institute, and that the first three health districts include Ekurhuleni, Tshwane and the West Rand. Data on the numbers trained to date were not available from the Department, but the respondent indicated that the intervention aims to "*train everybody, from the security guy at the gate, to the clinician on dealing with issues that limit MSM access to our services*". The training will reportedly primarily focus on clinics, but it was indicated that it would ultimately cover "*the entire spectrum of healthcare services, from primary health care, to CHCs, to your district hospital*".

Another Gauteng respondent indicated that the non-governmental organisation, OUT, has a clinic in the province (located in Hatfield, Pretoria), and that MSM are also referred to the OUT clinic for treatment, if this is within reasonable reach for the client. It was indicated that the Gauteng Department of Health also directly funds OUT for a peer education programme for MSM. It was reported that in the current financial year, a total of 8000 individuals were reached through this peer education programme in the province.

The Gauteng Department of Health also reports that it directly funds the Soweto HIV/AIDS Counsellors Association (SOHACA) for its peer education programme, which provides general support and counselling for people affected and infected by HIV and AIDS, including children, women, and the gay, lesbian and transgender community. It was indicated that the Department - as part of its imperative to minimise stigma - funds the Association.

The respondents did not discuss support provided by ICAP in the Province, but this is outlined further below.

KwaZulu Natal Provincial Department of Health

The KwaZulu Natal Department of Health (Zululand district) indicated that they were not aware of any NGOs or partners in the district addressing the issue of MSM. The respondent indicated, however, that the Department was very eager to consider how to better support MSM in terms of prevention, treatment and care, but that the Department has no sense of the need in this regard. As the respondent commented:

> "*We want to provide [services for MSM] but we don't have clients who say they are MSM. We'd like to find out from them what protection we can provide for them, what capacity building we can provide for them, how we can help them…information or anything that will help them. But we don't know about them: who they are or what they want. If they are there, like the sex workers, then they could have a forum where we could support them*".

The respondent indicated that one of the factors that potentially fed into the perceived invisibility of MSM in the province related to the fact that large areas of KZN are rural, and that "traditional" norms and values militate against open discussion of issues pertaining to MSM, which is considered by many to be "taboo".

The respondent acknowledged that KwaZulu Natal had not done anything active to challenge MSM to come forward and to encourage them to express their needs from a health perspective and that it was "*necessary to implement interventions to help them come out*", but that the Department was unclear about how people would respond to such potential interventions, given the extent of conservative views, especially in rural areas.

The respondent indicated that one possible area of initial intervention – although this had not been decided on – would be to train nurses from

community outreach teams on MSM, including sensitisation on MSM, as well as MSM service provision.

Section 7 provides information from non-governmental respondents on programmes and services that are taking place in the province, including ICAP (sensitisation training for DoH staff), ICAP's Mosaic programme, and related.

LIMPOPO DEPARTMENT OF HEALTH

The province has signed an agreement with the Anova Health Institute to extend MSM competent services in the province, most notably in the Mopani and Vhembe districts. Anova and the department have jointly launched a MSM-focused Regional Leadership Site to drive this process, in Tzaneen. This was followed by the first MSM symposium in Limpopo in October. The respondent from the Limpopo Department of Health also indicated that ICAP undertakes sensitisation training in the Capricorn District, as well as prevention education programmes accompanying the distribution of lubricants and condoms.

NORTHERN CAPE DEPARTMENT OF HEALTH

The respondent from the Northern Cape indicated that apart from integrated services available to all clients, the Province currently has a partnership with ICAP, that has developed a programme to train staff to deal with MSM cases and to promote access for MSM. It was indicated that ICAP is currently providing the training in the Francis Baart District (around Kimberly), but has not expanded from this base to date, although the province hopes to have the training conducted across the province, which includes approximately 210 health facilities. The initial focus, however, will reportedly be on high transmission areas, although the respondent indicated that data in this regard was not available. The respondent specified that the training focused not only on MSM, but included all the groups specified in the "key populations".

The respondent indicated that there was little additional NGO activity in the Province regarding MSM, and indicated that "… *a lot of NGOs or developmental partners don't want to come to the Northern Cape because of the distances. If you have to travel to one district to another the distance is vast. It's not easy to get in your car and travel. To get to Springbok you travel a day*".

The respondent indicated that condom distribution was sometimes a challenge in the province, as there was only one truck responsible for distributing condoms to facilities in the province. This reportedly resulted in condom shortages on occasion. It was indicated that an NGO, the Society for Family Health was one of the entities in the province that distributed condoms in far-reaching areas and that, in the Siyanda District, TB and HIV Care Association focused on condom access and male sexual health, although this was not specifically targeted at MSM.

Finally, the respondent indicated that the Department aimed to distribute lubrication, but was awaiting the go-ahead from national government to order supplies. The respondent indicated that he understood that a "*company has donated lubrication to national and we are awaiting them on that*".

NORTH WEST PROVINCIAL DEPARTMENT OF HEALTH

The respondent from the North West Department of Health was not aware of any MSM activities within the Province already underway but noted that an MOU for the extension of MSM competency training has recently been signed with Anova.

Other NGO respondents interviewed in this process did not report that they work in the province, although there are some small local NGO's in parts of the province.

MPUMALANGA PROVINCIAL DEPARTMENT OF HEALTH

The respondent from the Mpumalanga Department of Health was not available for interview during the assessment time frame. However, the Department is actively partnering in the establishment of MSM-competency training in the province, with an Anova Regional Leadership Site officially opened in Nelspruit by senior Department officials in mid-2013 and another clinic due to open on World AIDS Day 2013 in Ermelo. The Department is also aware and supportive of Project Boithato's work in the province.

WESTERN CAPE DEPARTMENT OF HEALTH

Similar to the Gauteng Department of Health, the respondent from the Western Cape Department indicated that services are provided to MSM along with the general population, and that no specific government

interventions were in place at scale in this regard in the Province. The respondent indicated that testing was available at all facilities, and that condoms were also made available at all facilities. However, it was indicated that counselling and treatment was not available at district level hospitals and some clinics. The respondent indicated that in terms of MSM in particular, the Department had made a decision to make lubrication available at all health facilities, and that this was underway. He acknowledged that the Province was aware of the imperative to address key populations, including MSM, but that issues pertaining to key populations had yet to be fully addressed.

The respondent indicated that the City of Cape Town had opened three male clinics to provide men with access to preventative and curative services, and that MSM clientele reportedly access these. The clinics provide HIV testing and counselling, condom distribution, treatment of STIs, TB screening and other health services. The three clinics are located in Khayelitsha, Gugulethu and Bellville. The Anova Health institute supports the Khayalitsha and Bellville clinics.

The respondent indicated that there are also non-governmental organisations in the province that provide specific support to MSM. The respondent referred to the Anova-funded Health4Men clinic in Woodstock, which is run in partnership with the Department. The respondent indicated that Anova's MSM focus was considered a considerable asset in the Province, and that, as a result of the limited geographical spread and limited scope of MSM services, the City was in discussions with the Anova Health Institute to address this.

NON GOVERNMENTAL SECTOR

This section provides further detail on organisations already mentioned by government respondents, as well as additional detail on other organisations not mentioned.

THE ANOVA HEATH INSTITUTE

Anova has focused on MSM sexual health since 2008, through its Health4Men project which aims to provide access to "competent, prejudice-free sexual health care for men who have sex with men and the promotion of a sex-positive attitude among health care workers" (www.health4men.co.za). In this regard Anova established Africa's first two MSM sexual health Centres of Excellence (in the Western Cape and Gauteng), each supported by a network of MSM competent sites.

This process has allowed Anova to pioneer MSM-competent services within the public sector by developing and refining MSM-focused protocols and guidelines, in partnership with the Department of Health. In addition, direct service provision to MSM has allowed for the development of the largest database on MSM sexual health on the continent, which is a vital asset for Anova's ongoing biomedical and psychosocial research processes.

Anova has developed expertise in combination prevention methodologies, including prevention for positive MSM , PrEP, PEP and TasP, STI management, MSM-related mental health and working with particularly vulnerable MSM. The latter includes a harm-reduction programme for IDU MSM (with a needle exchange programme), MSM sex workers and displaced people, and transgender clients.

Anova has received funding from PEPFAR/USAID to extend MSM competence within the public health sector in five provinces through a tested model of sensitisation, training, mentoring and ongoing technical assistance to health workers.

This is currently being undertaken in the following geographical areas:

Province	District	Competent sites to date
Gauteng	CoJ, West Rand, Ekurhuleni, Tshwane, Sedibeng	23
Limpopo	Vhembe, Mopani	8
Mpumalanga	Ehlanzeni, Gert Sibande, Nkangala	18
North West	Dr K Kaunda, Bojanala, Dr R.S.M	0
Western Cape	Metro, Eden, Winelands	2
Total competent sites		**51**
Total competent clinicians		**235**
Total competent staff		**908**

As previously noted, during October 2013 Anova received an additonal grant from the Global Fund for AIDS, TB and Malaria (GFATM), through Right to Care, to extend this intervention into the remaining provinces (KwaZulu-Natal, Eastern Cape, Northern Cape and Free State) allowing for an integrated national response.

Anova has developed expertise in various forms of public engagement and messaging targeting diverse MSM groupings, including developing innovative media products ranging from print media to public billboards, and utilises mHealth. The latter includes the H4M mobi site (h4m.mobi), using cellular phone technology, where MSM can access information as well as post anonymous questions to Anova's medical team. Anova's outreach programme, referred to in published articles as *Ukwazana*, was developed in partnership with the University of Cambridge and addresses MSM sexual health and barriers to MSM accessing health care. The outreach model includes an emphasis on partnering with shebeen / tavern owners to disseminate topical MSM-specific information plus branded condoms and lubricant sachets. Anova's black condoms are in demand by various bodies, including SAPS and parliament.

Anova conducts both national and provincial MSM-related symposia aiming to disseminate its model of excellence in MSM sexual healthcare and has developed extensive training materials.

ICAP

ICAP, which has been operating since 2004, is situated at Columbia University, and aims to improve the health of families and communities through health system strengthening and has, to date, worked in 21 countries across the globe.

ICAP has been operating in South Africa since its inception year, initially with a focus on HIV prevention, care and support for the general population, using primarily a clinical approach. Since 2008, with the receipt of CDC funding, the Most at Risk Populations (MARPs) programme has been implemented, with a focus on prevention. ICAP's general population work is on-going, with foci on PMTCT and paediatric HIV, TB and HIV, the Medical Education Partnerships Initiative (MEPI) programme for nurses and the provision of technical assistance to government, among other areas.

According to the respondent from ICAP, the MARPs programme is essentially around prevention, and one component is a national capacity building programme in which they work with the NDoH and Provincial Departments around building capacity to work with mainly sex workers, IDUs and MSM. In order to implement the capacity building programme, ICAP contracts local partners (such as OUT in Gauteng and the DTHF in the Western Cape, amongst others) to conduct the sensitisation training with facility staff. In addition, ICAP conducts clinical training to improve clinical competence for managing cases for sex workers, MSM and IDUs, which are supported by a mentoring programme in a few health facilities. In terms of the sensitisation training referred to above, ICAP indicates that they worked with several partners to develop "an integrated sensitisation manual" and will be commencing with train-the-trainer processes using this manual this October, to be followed by pilot training in 2014.

In addition to the national capacity building programme, the ICAP respondent explained that its MSM programme is, principally, a combination prevention programme. ICAP reports that it completed a needs assessment around MSM programming in March 2012, and identified NGOs who were already working with, or who had the potential to work with, MSM in the geographical areas they had identified. The needs assessment established that there was a high level of duplication, and very little coordination across NGOs and that, in turn, many NGOs were competing for limited resources available for MSM work.

Consequently, ICAP developed a framework around a combination prevention programme using a "community of practice" approach, whereby

it brought identified NGOs together, and then allocated responsibility for various aspects of the programme. This programme is now known as the Mosaic Men's Health Initiative.

The respondent indicated that one example of Mosaic is that in Durban, the Durban Gay and Lesbian Centre provides peer counselling, SANCA does treatment for MSM who are also substance abusers, Lovelife works with young MSM people and Lifeline provides psychosocial support for MSM. The respondent indicated that "*this approach works well. It strengthens linkages between organisations, and enables us to provide a broad range of services. There is definitely a willingness to collaborate amongst the NGOs*". However, he added that the approach involved "*a lot of effort to bring people together*".

The table below indicates the provinces and areas that ICAP currently operates in, as well as where it plans to extend to in 2014:

Province	Current Locations	Locations to which the programmes will be extended
EC	Port Elizabeth	Buffalo City
FS	Bloemfontein	Lejwelaputswa District (around Welkom)
GP	Tshwane	Ekurhuleni
KzN	Durban Pietermaritzburg	Richards Bay Empangeni Areas surrounding Pietermaritzburg
LP	Polokwane	Sekhukhune Waterberg
NC	Kimberly	Additional Districts around Kimberly

The ICAP respondent noted that the organisation had tried to deliberately focus on the inclusion of both urban and rural areas, and that in 2014 they would also attempt to work in some "deep" rural areas, albeit that they had little experience in this regard. The respondent indicated that working across these different locales had revealed the extent to which local contextual issues impact on prevention. For example, it was reported that cultural and religious issues in Durban heavily impact on MSM access to support, whereas in a locale such as Kimberly, the risk issues are much more strongly linked to MSM who are abusing substances. This learning is seen to support the "community of practice" approach, such that programmes and interventions are shaped within a specific context, and with the cooperation and coordination of players operating within those contexts. As the respondent

commented, "*because the interventions are led by the community, they are much more contextualized, and much more sustainable*".

ICAP supplies Mosaic-branded condoms (male and "female" – the latter of which are being rebranded as "external" condoms for use in anal sex) and lubricants to many of its partner organisations, but these are currently in short supply as a result of budgetary constraints.

The respondent did not supply data on reach in terms of the Mosaic programme, but some of the Mosaic organisations were interviewed in the course of this process, and reach data is reported where this was available.

DIAMOND GAYS AND LESBIANS ORGANISATION

The Diamond Gay and Lesbian Organisation is one of the partners working with ICAP in the "community of practice" approach discussed above. The organisation deals with LGBTI populations, and reportedly focuses specifically on MSM sex workers in terms of HIV.

The organisation reported that its routine work involves door-to-door awareness raising, telephone counselling, and the organisation also participate in radio talk shows in which individuals are able to call in and ask questions about MSM. Its five-year plan is to increasingly offer workshops on MSM and HIV, facilitate film festivals that screen educational films on MSM issues, and to focus on additional awareness-raising activities. In addition to these activities, the organisation distributes condoms and lubricant to MSM (which are reportedly supplied by ICAP), but it is presently out of stock of condoms. The respondent indicated that MSM "*don't want the government Choice condoms*", and that their clients preferred the Mosaic condoms, which are both coloured and flavoured and, reportedly, larger than the Choice condoms.

The organisation reportedly has no office, and is currently running its operations from the house of the director/head.

In terms of its work with ICAP, Diamond is working with Lifeline in the Northern Cape, around Kimberly, to train health care workers on counselling and testing MSM. The respondent indicated that in some of their training, some healthcare workers started out "*not understanding at all what MSM is about*", and that is was challenging to change mind sets. It was reported that Diamond and Lifeline intend to work with the Department of Health (through ICAP) over the next eight years, providing training, monthly workshops, road shows and radio shows.

DURBAN LESBIAN AND GAY COMMUNITY HEALTH CENTRE

The Durban Centre is a drop-in centre that aims to provide "*safe and secure spaces for lesbians, transgender, gay, bisexual and intersex communities in Durban and KwaZulu Natal*".

The Centre provides services to LGBTI through counselling and support groups, HIV education and support, legal advice, and other social and health activities. The Centre provides HCT for MSM and other populations, as well as TB and STI screening services, and refers clients to suitable facilities, as relevant for treatment, as required.

The Centre also provides a mobile outreach service and they mobile clinic is taken to correctional services, tertiary institutions, taxi ranks and shopping centres. The respondent reported that reach tends to be greater when the mobile clinic is used for outreach. It was reported that there might be seven individuals a week who seek HIV services at the Centre, but up to 50 people are reached in one week in an outreach exercise (using 2 to 3 outreach offers).

The Centre has now partnered with ICAP, and intends to "*establish their grounding better first, and then to grow the programme and extend its reach*". The Centre has, through ICAP, also started sensitisation training for health care workers, and views itself as becoming a "*service providing space, as well as a training space*".

The organisation also disseminates DoH Choice condoms, Mosaic condoms (from ICAP) and lubricant from separate funding. The respondent was not able to provide an indication of reach.

LIFELINE DURBAN

Lifeline Durban is a forty-four year old institution with the core business of promoting emotional wellbeing. The organisation offers 24 hour a day counselling, 7 days a week (telephonic and face-to-face) and HIV testing and awareness. There is also a Training Department, which advances peer-to-peer programmes.

Lifeline has a "High Risk Project" which focuses on key populations, including sex workers, IDUs and MSM. The respondent indicated that the overall approach is to "*establish relationships. Starting with the counselling and emotional wellbeing focus, which then gets us to the testing phase. We assist with referrals to clinic and then work on plans with each client and then refer to social workers to continue*".

The peer-to-peer training programme, in turn, provides skills development in emotional wellness and, in this way, offers clients from high-risk groups an opportunity to learn and develop skills. They could then potentially become part of the outreach team who work with the peer-to-peer model. They then provide HIV support groups for key populations. The respondent indicated that "*65% of peer educators were high risk them selves*".

Lifeline Durban is one of ICAP's Mosaic partners, and also partners with MATCH (a research organisation) and SWEAT.

The respondent was not able to provide information on reach in terms of the high-risk project.

ECGLA (EASTERN CAPE GAY AND LESBIAN ASSOCIATION)

ECGLA is a small organisation that includes a Director, four outreach workers, a counsellor, six volunteers and support staff. The organisation assists LGBTI individuals in terms of HIV testing, TB screening, and diabetes testing, and will include testing for syphilis and Hepatitis B in the near future. The organisation indicated that they would be expanding their offerings to the heterosexual community, as "*we don't always hear from the gay community, as the EC is still very closed about any of these issues*".

The respondent reported that their staff from the organisation travel to people's homes for testing, as they do not have the funding for a centre. The outreach workers visit nightclubs and university campuses in order to create awareness.

The organisation received condoms for distribution from the DoH, and also distributes condoms from ICAP. ICAP also supplies lubricant, although both the ICAP condoms and lubricant are apparently not presently available. The respondent reported that the organisation also actively promotes the use of female condoms for anal sex, as research from Canada has indicated that these are considered comfortable for anal sex and also have a lower possibility of producing an allergic reaction. The organisation prefers to promote the DoH female condoms for these purposes, as the ICAP female condoms reportedly have a sponge with spermicide at the bottom, which makes them less appealing to MSM.

PROJECT BOITHATO

Project Boithato is a collaborative project of the University of California, San Francisco (UCSF) and the Anova Health Institute. The project is an adaption of the MPowerment Project in a rural South African setting. The MPowerment Project is a US HIV prevention programme for young gay and bisexual men that focuses on:

- "Personal and community empowerment
- Diffusion of new behaviours through social networks;
- Peer influence
- Putting HIV prevention within the context of other compelling issues for young gay/bisexual men (e.g. social issues)
- Community building
- Using gay-positive approaches" (http://caps.ucsf.edu/mpowerment/)

Project Boithato provided HIV interventions that focus on MSM. Currently, the project focuses on the Gert Sibande district, including almost all of the encompassed sub districts, excluding Depaleseng Sub-district. There is a project space in Ermelo, which is an informative safe and relaxing space for MSM. The Boithato project promotes safer sex unity among MSM and a community that is free from discrimination and stigma which both contribute to MSM being at risk for HIV. Project Boithato uses multi-level approaches addressing individual factors such as misperceptions about safe and unsafe sexual behaviour, interpersonal factors such as being unable to negotiate sexual situations, social/community level factors such as social stigma towards MSM, and environmental factors such as health services unfriendly to MSM. The project works in line with the NSP to provide an MSM targeted intervention. Additionally, it works in close cooperation with the Mpumalanga Department of Health. The project aims to use peer influence to recruit MSM into the project, believing that it is easier and more influential to glean information from your friends, as opposed to strangers. There is a Core Group made up of MSM volunteers. These members are the decision makers and plan social activities, including "Bar Zaps" (condom and lube education and distribution in bars). The Core Group members also recruit through informal outreach by spreading information through word of mouth and inviting friends to the project space. "Mgroup" are guided group discussions with between 8 to 12 men focusing on skills building in areas such as negotiating condom use, safer sex techniques, and how to encourage one another to test for HIV. Additionally, Mgroups have condom and lube demonstrations in a fun environment. Project Boithato's goal is to reduce unprotected anal sex, increase HIV testing at least every 6 months and for HIV positive MSM to get on ART at the right time and to take their medications regularly.

LIMPOPO LGBTI PROUDLY OUT

Limpopo's Proudly Out is a LGBTI-focused organisation that focuses on awareness and education about LGBTI, and also HIV safety and awareness for LGBTI. The organisation also takes a counsellor to its events and campaigns to provide counselling and testing services.

In terms of MSM specifically, the respondent indicated that they run workshops and provide education talks for MSM and try to "*…draw them out and to teach them how their behaviour puts them at risk*". The organisation offers a peer mentoring programme, and aims to get MSM to become involved and own their own processes. This programme has been extended to universities and colleges, but is not yet available in schools.

Since November 2012, the organisation has provided face-to-face counselling to 600 MSM in Polokwane, and has reached 3500 individuals through workshops and dialogues, or open discussions. The respondent indicated that the organisation tries to follow up the men that it reached by visiting drinking spots or telephoning them to "*check how they are doing*" and encourage healthy choices and active participation. However, the respondent noted that cultural "norms" impact heavily on MSM participation in the province, most notably in more rural areas, such as Venda. As the respondent commented: "I*n Venda it is extremely difficult because of the place and culture. This is big stigma. They don't want to hear about it [MSM]. They think we are promoting it. It doesn't exist here. You will bring it. If they had a safe place to go then maybe they wouldn't drink and carry on with the risky behaviour***".**

In addition to the awareness raising, peer mentoring and education programmes, Proudly Out also distributes condoms and lubricants. It was reported that the lubricants are now starting to be supplied by the Department of Health, and that up until recently, ICAP supplied both condoms and lubricants, which are presently not available. The Anova Health Institute is reportedly supplying condoms and lubricants in Venda and Mopane, but the respondent indicated that "*we always need more…though if we could, we'd ask for the loose ones rather than the bigger packs. They're easier to put in your pocket when you are out jolling [partying]*".

The testing kits reportedly come from the DoH and ICAP.

Proudly Out is also involved in training staff in the clinics to not treat MSM judgementally. The respondent indicated, however, that a core concern was that even if services become more MSM friendly, very few MSM come to the clinics when they have engaged in unsafe sex. The respondent reported that 6 out of 10 MSM they speak to are HIV positive, and yet they do not want to

be "caught out", as it results in losing their jobs, or being thrown out their homes.

Finally, the respondent indicated that local municipalities in Limpopo were beginning to come on board in terms of MSM. The respondent indicated that there was now a gender forum in place, which at least "*opens the doors for discussion*".

NATIONAL LGBTI HEALTH CAMPAIGN

The National LGBTI Health Campaign is located in Bloemfontein and focuses on LGBTI populations, including MSM. The organisation mainly focuses on outreach activities for LGBTI for advocacy and awareness raising purposes (including face to face counselling, community workshops and dialogues), and also facilitates support groups for LGBTI. The organisation also participates in radio programmes pertaining to LGBTI, and engages organisations such as the media and local churches.

In terms of HIV services, the Campaign provides HCT services, as well as testing support groups, and has staff placed at clinics in the area to support this. The testing kits are provided by the DoH. The Campaign also distributes condoms and lubrication (supplied by ICAP), and provides education on the use of lubricant as part of the distribution process. The respondent indicated that there is a need for more lubricant than they are currently supplied with. The Campaign also assists to trace HIV clients to support monitoring their progress and promoting adherence.

The respondent indicated that in terms of their current activities, the targets – which are usually always reached – include 800 people receiving HCT per month, 1000 people reached through door to door activities per month, 800 people reached through community dialogues per month and 160 people attending support groups per month.

OUT LGBT WELLBEING

The Gauteng-based OUT has a clinic in Pretoria, which has been in existence for twenty years, and provides health services to the lesbian, gay, bisexual and transgender communities. Their services include HIV counselling and testing, treatment, STI screening and general lifestyle advice and support. The respondent indicated that OUT presently has approximately 1000 clients on their clinic books.

OUT reports that it received its testing kits from the DoH, but is responsible for the procurement of its own condoms and lubrication. The respondent indicated that the clinic preferred to purchase coloured condoms, as they are "*more attractive to use*". The facility reports that it distributes more than 100 000 condoms and lubricants (packaged together) every year. These are distributed at the clinic, and also at shebeens and outreach spots in and around Pretoria.

Also in terms of prevention, OUT has a peer education programme, and also operates two websites, hosts an electronic newsletter, and runs an SMS service for their client targets. Relevant articles, news and education materials are also placed in the gay press. Psychosocial services are available on line, as well as on a face-to-face basis.

OUT is involved in advocacy work for LGBTI, which currently focuses on HIV and hate crime work. OUT represents LGBTI issues within the SANAC High Plenary, Programme Implementation Committee, the Women's Sector and the Research and Monitoring Task Team.

OUT indicates that it has played an active role in proposing a national programme to reach the MSM related targets in the current National Strategic Plan and to ensure inclusion of targets in the NSP for 2012 and beyond.

OUT is also a member of the African Men for Sexual Health and Rights (AMSHeR) and plays an active role to promote the interest of MSM on the continent.

In addition to the above, OUT works with ICAP in terms of its capacity building programme, and trains Department of Health workers in facilities on how to deal with key populations. At present, OUT is providing training in five provinces, including the Eastern Cape, Northern Cape, Free State, KwaZulu Natal and Limpopo.

The OUT respondent indicated that they are currently planning more focused programming in government clinics in Pretoria in terms of training, mentoring and outreach. The respondent indicated that through this strategy, they aimed to increase reach, as the OUT clinic only addressed "*a small percentage of the target group*". It was noted, however, that extending reach to LGBTI populations was a challenge, as "*a large percentage of them do not have very good health seeking behaviours. Activities are made very difficult by their own lack of health seeking behaviour*".

TRIANGLE PROJECT

The Triangle Project, which is based in the Western Cape, is an NGO that focuses on supporting LGBTI populations through education, advocacy and community awareness. In addition to its broader advocacy and awareness-raising work, the Triangle Project also provides specific health-related services to LGBTI populations.

Triangle has its own clinic in Mowbray for LGBTI, which operates at night specifically for MSM. The clinic provides rapid HIV testing, along with pre and post test counselling, which Triangle considers a priority. If a client tests positive in the rapid test, bloods are sent to a laboratory for a confirmatory ELISA test. The clinic also sends out bloods for CD4 counts, viral loads and STI testing. While general medical consultations are available, if a client requires ART, they are referred to relevant community health clinics for treatment. The respondent indicated that approximately 300 clients receive HIV counselling per month at the facility.

The clinic also offers one-on-one psychosocial counselling, and safe sex training.

The Triangle Project reports that it purchases its own testing kits for rapid testing, and these are obtained from a pharmaceutical company. The respondent indicated that obtaining rapid testing kits from the DoH or another source would be "hugely beneficial" to the organisation, as the kits are costly. The Project does receive lubricants and condoms from the DoH, as well as NACOSA.

The project did not provide reach data.

WITS REPRODUCTIVE HEALTH AND HIV INSTITUTE (WITS RHI)

The Wits RHI is a research institute of the University of the Witwatersrand and is part of the Faculty of Health Sciences. Established in 1994 as the Reproductive Health Research Unit (RHRU), the Institute was formed on 1 October 2010 through a merger with Enhancing Children's HIV Outcomes (ECHO).

The WRHI conducts research and provides programmatic support, training, policy development and health system strengthening.

The Wits RHI reported that they do not have any formal programming for MSM. It was indicated that at one point, the organisation was working with MSM sex workers in Hillbrow, but that funding for the initiative was halted. The respondent indicated that the Wits RHI was intending to revisit MSM work, with a specific focus on research into HIV prevalence and STI prevalence, and

factors such as resistance to antiretrovirals. It was indicated that there was a possibility that this would be linked to the Institute's broader sex worker programme and work with migrating truckers, but this has not been decided.

DESMOND TUTU HIV FOUNDATION

The Desmond Tutu HIV Foundation (DTHF) developed from the HIV Research Unit at New Somerset Hospital in the early 1990's, which has since been registered as a Section 21 non profit organisation, supported by Emeritus Archbishop Desmond Tutu and Mrs Leah Tutu. The Foundation's activities include HIV prevention, treatment, and training as well as tuberculosis screening and management among some of the most vulnerable communities of the Western Cape. The work is underpinned by academic research undertaken by the Desmond Tutu HIV Centre (DTHC). The Centre, based at the University of Cape Town's Institute of Infectious Disease and Molecular Medicine, operates symbiotically with the Foundation's local field sites in the Nyanga area of Cape Town and Masiphumelele, Noordhoek.

The Foundation has a Men's Health Division, which explores the incidence of HIV among marginalised groups such as men who have sex with men (MSM). The Division aims to support MSM, and to change pervasive negative perceptions of MSM through research and community engagement.

The DTHF indicated that while its core mandate is research, the nature of the research processes is both proactive and action-oriented. As such, MSM research participants receive screening, treatment, as well as referrals for comprehensive medical care. It was indicated that to date, 525 MSM have participated in two action-oriented research studies in this regard.

In addition to these research studies, the DTHF manages a community engagement programme in which they support 6 different groups of MSM in townships, which aim to promote proactive health seeking behaviour, as well as providing appropriate referrals and related support.

The DTHF indicates that it works in close partnership with the Health4Men clinics in the Western Cape, and refers study participants to Health4Men for services. The DTHF also works in collaboration with OUT and the Triangle Project.

SOUTH AFRICAN GAY AND LESBIAN ALLIANCE AGAINST DEFAMATION (GLAAD)

The SA Gay & Lesbian Alliance Against Defamation (SA GLAAD) is an equal civil rights advocacy group that documents and responds to homophobia and heterosexism in the South African popular media and society. The respondent indicated that responses to defamation range from letter writing campaigns, to direct action activism and protests. The goal of SA GLAAD is the elimination of anti gay, lesbian, bisexual, transgendered and intersex bias in reporting, television and film. In general, GLAAD does not directly interface with the health system and does not have health-related programming.

The GLAAD respondent from the Free State branch interviewed for these purposes indicated that GLAAD FS has adopted a hands-on approach to the rights of the individual, and continuously assists members of the LGBTI community to access services provided by the S.A. Human Rights Commission, the Equality Courts, and similar institutions. GLAAD also provides support during these processes and, if possible, facilitates alternative dispute resolution processes.

While GLAAD focuses on supporting LGBTI populations in general, the respondent indicated that the MSM community in the Free State (specifically in Bloemfontein) is "enormous" and that it is a significant challenge that high levels of stigma exist, such that MSM is practiced "in total secrecy".

SA GLAAD FS has signed a Memorandum of Understanding with the S. A. Human Rights Commission, which provides assistance and legal recourse for the violation of LGBTI Human Rights. No formal agreements exist between SA GLAAD FS and any healthcare service providers.

THE NETWORKING HIV/AIDS COMMUNITY OF SOUTH AFRICA (NACOSA)

NACOSA is a civil society network of organisations working in the HIV, AIDS, TB and related social development fields. It has over 1200 members comprised on CBOs and not-for-profit organisations, and aims to "turn the tide on HIV/AIDS and TB through *grant management*, *capacity building*, and *networking and promoting dialogue*" (*Global Fund Round 9 Phase II: Men having Sex with Men/Lesbian, Gay, Bisexual, Transgender and Intersexed (MSM/LGBTI), Tertiary Institution Programme Description*, 2013)

According to NACOSA's 2013 submission to the Global Find, NACOSA's MSM programme was initiated in 2008 with sensitivity training in the Western Cape,

which was taken up by NASTAD (National Alliance of State and Territorial Directors) and the CDC, South Africa.

In December 2009 NACOSA was selected as a civil society Principal Recipient of GF Round 9 funding, which allowed the organisation to channel GF monies to local organisations in the HIV/AIDS sector. A large proportion of NACOSA's grant focused on most-at-risk populations (MARPS). NACOSA directs funds to projects aimed at abused and raped women, sex workers, and men who have sex with men (MSM).

The NACOSA respondent indicated that the MSM activities covered in Phase I (and implemented by Anova's Health4Men project and the Triangle Project) included HCT, peer educator outreach (with the distribution of condoms and lubricants) and IEC materials development and dissemination. It also further covered aspects of prevention through risk reduction workshops and support groups. Access to care was addressed through sensitisation trainings of health care professionals. The 2013 GF submission indicates that these activities will continue, while NACOSA will focus on a university campus-based programme for Phase II of the current Global Fund country programme, which will be starting in October 2013.

In terms of the campus-based programme, the respondent indicated that the core objectives are:

- To conduct Rapid KAP Surveys at 12 identified universities – Extension Period before phase II of the Global Fund grant starts - June to September 2013
- To establish and strengthen MSM/LGBTI friendly health services on campuses – Phase II, from October 2013
- To create a Supportive Environment for MSM/LGBTI students and staff to access health care
- To co-ordinate, manage, monitor and evaluate the programme to ensure successful implementation

In the course of Phase I, an electronic sex health survey was completed that focused on students in general, but also LGBTI, including MSM. In Phase II, 13 higher education institutions (with the possibility of the remaining ten universities being addressed later in the programme) will each receive a coordinator, who will be based at the HIV Unit on campus. The respondent indicated that their role will be to focus on key populations, including MSM, and that key activities will include HCT, referral for ART (through the campus health facilities), psychosocial support, risk-reduction counselling and putting support groups in place. In addition, the programme will focus on initiating campus dialogues with and between students and staff, and ensuring that MSM are "not overlooked" in general HIV drives on campus. The programme

will also include sensitisation training for health staff and academic staff on campus.

The respondent indicated that there was a need to consider appropriately branded student condoms and lubrication packs for MSM students, as well as the printing of IEC materials. It was indicated that there was a lack of funding for these specific activities.

SUMMARY OF REACH OF NON-GOVERNMENTAL SERVICES AND PROGRAMMES

The table below provides a summary of the reach data reported by organisations that were able to do so in the course of the interviews. As a result of this data being incomplete, it does not provide a comprehensive sense of reach for MSM programmes and services,

Organisation	Programme/s or Services	Location	Reach
Anova Health Institute's Health4Men programme	Sensitivity and clinical training and mentoring to DoH healthcare workers	GP WC LP MP NW KZN EC FS NC	
	HCT, combination prevention and treatment services for MSM	Johannesburg (Simon Nkoli, Zola CHC and Chiawelo CHC) Cape Town (Ivan Toms, Belville and Khayelitsha)	The two Centres of Excellence (Simon Nkoli and Ivan Toms) have reached close to 10 000 known MSM with health care, of whom currently 1882 are HIV positive and in care, and 1226 are receiving antiretroviral therapy.
Anova Health Institute & UCSF	Project Boithato	Ermelo Nelspruit	
ICAP	Sentitisation training for Government facility staff to deal with "key populations"	NC – Kimberly FS - Bloemfontein, EC – PE LP - Polokwane, KzN – Durban and Pietermaritzburg	Data not provided

Organisation	Programme/s or Services	Location	Reach
		GP - Tshwane	
	Mosaic: combination prevention through community of practice approach with local partners, including HCT, condoms and lubricant distribution, peer education, psychosocial support.	NC – Kimberly FS - Bloemfontein, EC – PE LP - Polokwane, KzN – Durban and Pietermaritzburg GP - Tshwane	Data not provided
Diamond Gays and Lesbians Organisation	Awareness raising (including media such as radio), peer education, counselling for MSM, with a specific focus on MSM sex workers	NC - Kimberly	Data not provided
	Works with ICAP and Lifeline to train DoH staff on counselling and testing for MSM	NC - Kimberly	Data not provided
Durban Lesbian and Gay Community Health Centre	HCT and STI and TB screening	Durban and KzN	7 per week through Centre doors, and 50 per week when doing outreach
Lifeline Durban	Counselling high risk populations, testing, peer-to-peer training, outreach	KzN - Durban and surrounds	4500 risk reduction clients in 2012 (excluding once-off visits) This increased from 3500 the previous year
ECGLA	HIV testing, TB screening, outreach	EC	Data not provided
Limpopo LGBTI Proudly out	Awareness and education Counselling Workshops HIV testing Condom and lubricant distribution Staff training at clinics	LP – Polokwane and other areas across the province (incl. Mopani and Venda)	Face to face counselling to 600 MSM in last financial year Reached 3500 individuals through

Organisation	Programme/s or Services	Location	Reach
			workshops
South African Gay and Lesbian Alliance (GLAAD)	Civil rights advocacy for LGBTI, but not focused on the health sector or access to health specifically	National but branch in Free State interviewed	N/A
National LGBTI Health Campaign	Advocacy and awareness raising with LGBTI HCT for LGBTI Condom and lubricant distribution and education on lubricants Client tracing	FS - Bloemfontein	HCT for LGBTI = 800 per month Door to door outreach 1000 per month Community dialogues 800 pm Support groups 160 pm
OUT	Advocacy Psychosocial Support IEC HCT STI Treatment	Gauteng - Pretoria	1000 clients on clinical books
	Training of healthcare workers on key populations in five provinces through ICAP	EC NC FS KzN LP	No data
Triangle Project	Rapid testing for MSM Pre and post test counselling Sending bloods to labs for CD4, viral load and STI General medical	WC - Mowbray	300 client counselled per month
NACOSA	Sensitivity training HCT Peer outreach IEC materials Distribution of condoms and lubricant (Implemented by H4M and Triangle)		No data
	To commence:	13 universities	Still being

Organisation	Programme/s or Services	Location	Reach
	Campus-based MSM programme: HCT Counselling Staff sensitization		planned
DTHF	Action-oriented research with screening, treatment and referrals	WC	525 participants in action studies
SHIPP	Small funding to local CBOs for MSM prevention and condom distribution	MP – Gert Sibande KzN – to be extended into Zululand	No data

PRIVATE PRACTITIONERS

In addition to the NGO respondents above, the Singizi team also interviewed two private practitioners in order to understand service provision at the level of the private practice.

The private practitioners indicated that their provision of services in a perceived safe space for MSM had largely grown and developed on the basis of word of mouth, and that their clients – who can afford medical cover – prefer to receive medical care from doctors who have a pre-established reputation for being MSM-friendly.

Both practitioners indicated, however, that unlike self-proclaimed LGBTI and MSM organisations, private practitioners tend not to advertise their services as "MSM" for fear of alienating potentially homophobic clientele. One respondent indicated that even advertising a practice as a practice that also provides HIV services tends to alienate other clients and stigmatise the practice. The respondent indicated that he knew of a practitioner who advertised her HIV services, and landed up having to close the practice down – both because HIV clients did not want their status known and because other clients did not want to be associated with a HIV service.

One respondent indicated that it was his perception that there seemed to be a diminished number of private practitioners providing safe spaces for MSM service provision. He indicated that "*back in the eighties and nineties, there were a lot more [private practitioners]…when everything was more underground. There were several GPs you would know about that would provide a sympathetic ear*". At the same time, however, medical aids "targeted" practitioners providing HIV services, and had exclusionary policies in place, such that those who tended to seek medical help for HIV needed to cover this privately. The respondent indicated that currently, it seemed to him that "*the numbers of sympathetic ears have diminished – unless I am not in touch with new blood coming in. I have a sense that the average age of GPs has remained the same, and there has been a lot of emigration. I know fewer GPs now providing MSM services*".

One respondent indicated that there was a need for the strengthening of a community of practitioners who could better support MSM clients and each other as practitioners. The respondent indicated that "*lots of practitioners are solo practitioners, who end up doing a lot of STI and HIV work, and they burn out*". A community of practitioners, however, could potentially reduce the burden on individual GPs, and could also potentially serve as an opportunity to extend outreach. The respondent suggested that, for example, linkages would be created between areas of practice such as Sandton and Alexandra, such that access was less limited to wealthy areas. The respondent suggested that the advent of National Health Insurance could support such interventions, as the state would "*end up covering the costs of those who are unemployed*".

MSM Work supported by Donor, Technical Support and Umbrella Organisations

This section reviews respondents' contributions from donor, technical support and umbrella organisations, such as SANAC.

South African National AIDS Council (SANAC)

One of the SANAC respondents indicated that the Country Co-ordinating Mechanism for South Africa had submitted a request for HIV renewal funding from the Global Fund in May 2013, and this has been approved. The request indicates that the key foci for GF funding include the following:

a. ***Strengthen and expand treatment, care and support*** that includes the provision of antiretroviral therapy; a convenient chronic diseases drug delivery system for patients stabilised on ART, adherence support, monitoring of outcomes, pharmaco-vigilance, drug resistance monitoring, as well as targeted support to Orphans and Vulnerable Children (OVC);

b. ***Deliver a package of combination prevention services tailored for neglected designated key populations****, which* represent a large proportion of the new cases in concentrated target areas**.** Key populations include: Victims of Gender Based Violence (GBV); Sex workers (SWs); Men who have sex with men (MSM) and Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersexed (LGBTI) persons; Prisoners, Low socioeconomic populations (incl. farmers and other hard to reach populations), Uncircumcised Men and Youth (Young Women and Men);

c. ***Create an enabling environment*** to support community systems strengthening and the implementation of effective programme management and monitoring (CCM Request for HIV Renewal to the Global Fund, 31 May 2013).

As evidenced, the renewal again includes a focus on MSM, and the respondent indicated that what was significant in this regard is that previous GF funding for MSM had been in the region of approximately $500 000. The respondent indicated that this has now been increased to approximately $11 million (although allocations have not yet been finalised). The respondent indicated that this represented a "*dramatic increase*" in funding going to the sector.

The respondent indicated that a core component of the MSM work will take place through the NACOSA university programme (described above). In addition, there will be work supporting combination prevention, as well a work supporting social mobilisation.

The respondent indicated that the challenges pertaining to the MSM sector and programmatic planning are threefold. On the one hand, the respondent indicated that there is a lack of coordination in the sector. It was reported that SANAC held meetings with GF-funded and PEPFAR-funded partners working with MSM in order to "*compare what each are doing, so that we don't have duplication…so we are talking about it and about what makes a good health organisation*". The respondent indicated, however, that there was no comprehensive list of MSM service and programme providers, and that a mapping was required in order to develop a better sense of provision in the sector. The respondent indicated that SANAC was working on a mapping process, but that nothing substantial in this regard had been developed to date. Another SANAC respondent indicated that from his perspective, much of the work around MSM was focused in Gauteng (primarily in and around Johannesburg) and in the Western Cape (around Cape Town), and that MSM work in other areas tended to be piecemeal and small scale, and that there was a significant need for national coordination of MSM efforts.

The respondent indicated that the second challenge in terms of planning for MSM programming pertained to the view that many MSM organisations providing services (especially those at a local and community level) were not structurally very strong. As the respondent commented: "*the organisations within the [MSM] sector are not necessarily as strong as other organisations [non MSM organisations]. There are some [MSM organisations] that are a lot stronger than others. So, if they received funding…well, they need to be strong to meet funders' requirements. Whether it is funding from National Government or from external funders*". A respondent commented further "*some organisations think they are strong, but it is not supported by processes and systems. You need bi-directional accountability. You can say one thing, but you need to deliver. You need to show the outcomes they bring. And for that you need strong organisations and you need organisations to work optimally as well*".

The third challenge related to programmatic planning pertains to a lack of understanding of the size and the concomitant needs of the MSM sector, not least as a result of reluctance by many MSM to identify themselves as such. The respondent commented that "*when we put in the GF proposal, we could say that we will reach a certain amount of people. But we can't get a clear picture of how many need the services. Funders want to know what the gap is. Because we don't have numbers, we don't have the services mapped clearly enough. But it's not exactly clear where there are gaps, and what the extent of the gaps are*". The respondent added, "*the GF doesn't want to put in more funding unless we can show where the gaps are. We've done some of the work now, but it hasn't been enough. There is a need to establish the size of the need. And how we can respond to that gap*".

The respondent indicated that the lack of clear data on MSM also fed into debates about the extent to which the sector needs support. The respondent commented that in "*all the talk about key populations, one message that we are getting from organisations like the HSRC, for example, is that it's the general population at risk, and they say we shouldn't focus on key populations. So there is a bit of debate going on here*". The respondent also indicated that the lack of data also fed into "*battles over resources*".

SANAC LGBTI SECTOR

The SANAC LGBTI Sector consists of service providers who have done most of the groundwork in research, advocacy, training, treatment, support and care for the LGBTI community. The sector is a coordinating mechanism, linking organisational initiatives to the work of SANAC, rather than an implementing body.

These service providers are OUT in Pretoria, ICAP-South Africa, Durban Gay and Lesbian Centre, Pietermaritzburg Gay and Lesbian Network, NACOSA, Triangle Project, Anova Health Institute, Desmond Tutu HIV Foundation Cape Town, Gender Dynamix and Intersex South Africa.

The sector has developed an activity plan, available in summary on the SANAC website:

Sector Plans

1. Review plans of Government Departments, other identified sectors and Provincial Government for inclusion and start to build relationships.

2. Audit of current MSM/LGBTI service delivery by Sector members. Costing thereof, funding sources current and on medium and long term.

3. Development of communication strategy. It will include external liaison as well as consistent internal messaging (for example PEP for sexual prevention). Build relationship with communication with the aim of on-going integration. Dissemination of various fact sheets on lesbian/transgender/intersex vulnerabilities, and patriarchal masculinities.

4. On-going advocacy for the procurement of water based lubrication, PEP and PrEP, female condoms (also for anal sex). For inclusion in next Government budget and based on partners' gap analysis.

5. Integration of various trainings within the Regional Training Centres. These are the key population manual, Nurse Initiated Management of Antiretroviral therapy (NIMART) and Post Exposure Prophylaxis (PEP). On-going advocacy within NDOH to achieve this for both health care workers and community

outreach workers.

6. Advocate with NDOH for the rollout of the Service Guidelines to Key Populations. Advocate and institute with NDOH High Transmission Unit for a permanent Key Population Reference Group

7. Develop M&E strategy and plan. To include monitoring within the mainstream sector from a ward level and up. Also to develop Sector M& E framework to collate client stats on quarterly basis which will include services used, hate incidents, and experiences with mainstream health

8. Integrate with research Technical Task Team. Priorities are prevalence for lesbian/transgender/intersex people

9. Develop comprehensive resource lists and link with current directories such as HIV 911

10. Explore possibility of "health passport"" which clients can use between different service providers

RIGHT TO CARE/ GLOBAL FUND PR

Right to Care is the Principal Recipient for the GF, responsible for MSM (selected under Round 10). This means that RTC has responsibility for allocating grants in a number of areas. Thus far, requests for proposals have been made and, at the point of the interview process, a review of the proposals was about to be undertaken.

This area of work includes that of building staff capacity in government health facilities so as to provide "MSM competent and LGBTI effective HIV-related services – Programme Area 2" (*Right to Care Sub-Recipient Selection Process Document, August 2013*). The capacity building component will be covered in the Eastern Cape, Free State, KwaZulu Natal and the Northern Cape. As mentioned earlier in this document, this work has been awarded to Anova.

The second component of work is the "community engagement and peer education for MSM/LGBTI people to facilitate referrals to appropriate health services and conduct community-based adherence and retention in care activities – Programme Area 3". This is also to be based in the above four provinces. No award has been made following the first applications, and this will be reopened in the future

The core activities will focus on

- Establish one MSM and LGBTI Centre of Excellence and strengthen the capacity of Primary Health Care facilities to provide comprehensive HIV treatment and preventions services for MSM and LGBTI in four provinces.

    - Establishment of one Centre of Excellence site in four previously un-served provinces;
    - Establishment of fifty-nine MSM/LGBTI-competent PHC facilities
    - Train and mentor Department of Health staff to be able to deliver MSM/LGBTI competent PHC services
    - Deployment of Peer Educators for community mobilisation and public education activities aimed at both HIV and STI prevention, and linking MSM and LGBTI to care
    - MSM and LGBTI-specific information, communication and education (IEC) materials developed/printed/distributed
    - Social networking technologies optimized for improved health outcomes and service utilization.
- Conduct ethnographic mapping and repeated KAP studies to inform the need for and content of HIV prevention and treatment services provided to MSM and LGBTI
    - Conduct ethnographic mapping
    - Conduct repeated KAP studies

Over and above this role, Right to Care has a programme in which they work in prisons. They work with 11 facilities/management areas and provide programmes to support HIV counselling and testing and TB screening. They also provide condoms and lubricants for prisons nationally.

US CENTRES FOR DISEASE CONTROL AND PREVENTION (CDC)

The CDC is funding several programmes in South Africa, focused on prevention (behavioural, structural and biomedical). ICAP is their main implementing partner, and they use a community of practice model described in the previous section.

The CDC has funded the HSRC to develop a package of services for key populations, and this package has now been handed over to ICAP for implementation.

One of the CDC respondents indicated that there had been significant changes in terms of the introduction of MSM services and programming in the last few years. As the respondent commented, "*there has been an enormous change in the last three years. When I first arrived here at the beginning of 2010, I was surprised by the lack of work in this area. We brought in someone to do an assessment, and they found that there was very little work being done with HIV positive MSM, and certainly no co-ordination. This has changed through the work done by organizations like Anova's Health4Men project, the work in Cape Town and the LGBTI lobby in SANAC. The real focus now is on co-ordination of the various activities*".

FHI360

FHI360 indicated that they are a public health organisation that operates in sixty countries worldwide. Their focus pertains to public health, education and research and development in terms of gender issues. The respondent indicated that they do not have any service provision programmes in South Africa, but provide technical support on issues pertaining to gender to the NDOH and SANAC.

HIVOS

HIVOS is a humanist development organisation with four core programmes:

- Sexual development and rights programmes for LGBTI – regional SADC countries
- Civic voice building programme – multi agency grant initiative - National
- Gender programme – Gender Based Violence, HIV - National
- Refugee rights programme – National.

HIVOS does not do programming as such, but provides technical capacity building services, grant making, capacity development and network building with many partners based in South Africa and Southern Africa.

SHIPP

SHIPP is a flagship USAID funded project with three core functions:

- Create an enabling environment in which Government is able to deliver programmes at national, provincial and local levels.
- Develop capacity to deliver combination treatment and prevention programmes to key populations
- Work with civil society, CBOs and NGOs to scale up combination prevention programmes.

SHIPP does not directly provide services, but rather focuses on technical assistance and capacity building.

At a national level, SHIPP works with key departments to support them to develop a coherent response to the national strategy. They report that they provide technical assistance and guidance to the NDoH, Department of Basic Education, Department of Higher Education and Training, Department of Public Service and Administration, Department of Social Development, SANAC and the Office of the Deputy President.

In relation to MSM, SHIPP has been involved in the development of a sexuality education programme for Grades 6 to 10, which will be rolled out in schools. They are working with DPSA in terms of the new Civil Service Act, and there are elements around homophobia in the guidelines that SHIPP is reportedly developing.

In relation to key populations, SHIPP focuses on MSM, sex workers, youth and migrant men. SHIPP works in Gauteng, KwaZulu Natal and Mpumalanga, principally at a district level with the District AIDS Councils and Local AIDS Councils. The respondent indicated that in this regard SHIPP works with the District AIDS Councils to consider the operationalization of the Operational Guidelines on Key Populations.

Also at a district level, SHIPP provide small grants to CBOs to undertake specific community based activities around combination prevention. It was reported that one of the key threads of their work with MSM is working with CBOs to develop programmes around MSM. In Gert Sibande, they are working with an organization to support condom distribution, and this is also going to be rolled out in the Zululand District.

AMSHER

AMSHER is a regional organisation with a secretariat based in South Africa, but the respondent reported that the majority of their work takes place outside of the country. AMSHER broadly supports LGBTI rights through the capacity building of country-based civil society organisations to engage in advocacy and to provide services. AMSHER does not engage with the state directly, but works through its member organisations to advocate for LGBTI rights.

At the regional level, AMSHER engages at the level of the AU and African Commission, and also convenes regional conversations with national institutions in a facilitated manner to discuss national interventions and best practices, including issues pertaining to LGBTI and HIV.

AMSHER has three core programmes, including MSM and health, policy and law and movement building.

The organisation OUT, described above in this document, is a key AMSHER member organisation in South Africa. The respondent referred Singizi to OUT for further information.

UNAIDS

The UNAIDS respondent indicated that the organisation does not fund programmes, but reviews programmatic areas and identifies where the gaps are in this regard. Their focus is on issues of human rights, advocacy and capacity building.

The respondent indicated that a substantial portion of the recent work has been with IDUs and that UNAIDS has recently released global technical guidelines in this regard.

In terms of MSM, UNAIDS reports that it has been providing technical support to the Department of Health regarding the implementation of the Operational Guidelines for Key Populations. They are also working with the NDoH to set up a Technical Forum for Key Populations, which will bring together all the major players in this area and co-ordinate activities in relation to key populations. The respondent indicated that they hoped to have the Forum operational by the end of 2013.

The respondent suggested that the Forum would help to avoid overlaps in programming and identify gaps where there is a need to mobilise resources and determine the priorities for programming.

The respondent indicated that while there was a lot of work being conducted on key populations, much of this was concentrated in urban areas in Gauteng, the Western Cape and, to some extent, KwaZulu Natal. The respondent suggested that this needed to be reviewed and opportunities for expansion considered.

4.D: RESEARCH ON MSM AND HIV

RESEARCH ON MSM HIV INCIDENCE AND PREVALENCE

GOVERNMENT DATA ON MSM HIV INCIDENCE AND PREVALENCE

The National Department of Health indicated that government data on HIV incidence and prevalence among MSM was a challenge, as the government has not disaggregated its data down to the level of key populations. The respondent indicated that the daily registers used in facilities do not take headcounts of identified key population groups and, as such, no base data is available in this regard. The respondent commented that as a result, South Africa has not been able to report to UNGASS in terms of the Declaration of Commitment on HIV/AIDS, adopted in 2001 by all UN member states.

The respondent indicated that "*we have bits and pieces of information here and there. We're working with one consultant who's trying to collate some of what we already know and using this information he is trying to pull together on what's happening with MSM in South Africa. The minute we have that database, we are able to share with people with where support is needed. But right now, we don't really have a good picture in South Africa*".

The respondent also indicated that they were attempting to establish a Key Populations Forum, and that part of the Forum's role would be to review gaps in research studies on MSM.

All eight of the Provincial Departments of Health respondents interviewed indicated that they did not have any data on MSM incidence and prevalence, and that the only data in place pertained to prevalence amongst antenatal women. A respondent from the Gauteng Department indicated, however, that there was a perception that the "*figures are growing*". A respondent from the Western Cape Department indicated that one of the issues pertained to obtaining data from clients who did not want to openly identify as MSM for fear of stigma. As the respondent commented, "*they don't say they belong to this group of MSM. They just say 'hi, I have an STI'*".

The Northern Cape respondent indicated that they were working with ICAP to assist with the collection of data on MSM, but that they were "*just at the start of this*". The respondent indicated that "*we have the challenge of not having clear guidance about how to start. We don't have a database. We need to start reporting on those indicators*".

OTHER SOURCES OF MSM HIV INCIDENCE AND PREVALENCE DATA

The three most frequently cited sources of data on MSM HIV incidence and prevalence in this assessment were:

1. The JEMS study (2009), which was a collaborative study between the University of the Witwatersrand, the Human Sciences Research Council (HSRC) and the Medical Research Council. The component of the study that focused on prevalence was focused on Johannesburg and Durban, although other components of the study also collected data from Cape Town, Pretoria and Pietermaritzburg.

2. The Soweto Men's Study Survey conducted by UCSF and the PHRU on MSM in Soweto (also 2009)

3. The DTHF and Johns Hopkins HIV-risk behaviour and prevalence assessment of MSM from townships in and around Cape Town

A follow up study to the JEMS study, the "Marang Men's Project" is an HIV prevalence and behavioural survey among men who have sex with men (MSM) in Cape Town, Durban and Johannesburg, currently being conducted by the Human Sciences Research Council. The Mpumalanga Men's Study, conducted by UCSF and Anova, has presented initial prevalence data in a conference presentation. Additional national surveillance work in the MSM community is planned for 2014, led by UCSF.

This component of the rapid assessment does not review the findings of these studies, which are being addressed elsewhere.

Apart from these key studies, most organisations interviewed for these purposes were not aware of, or contributing to, further studies on incidence and prevalence (although some other studies are in progress). A SANAC respondent indicated that the key challenge was that there was no data available at a national level, and that the studies undertaken to date had focused on urban centres and identified "hot spots". As such, he indicated that a "*clear picture*" of MSM HIV prevalence in the country as a whole was not yet available.

OUT indicated that it was doing some additional work on MSM HIV prevalence in Pretoria. However, the research report is not available yet.

The DTHF indicated that the organisation has completed two MSM HIV prevalence studies in Cape Town, and that one of these was currently being prepared for publication.

Finally, the Anova Health Institute's Health4Men programme has completed an unpublished online survey of self-reported MSM prevalence in South Africa. The findings of the survey, conducted across all nine provinces, suggest that HIV

prevalence amongst MSM varies considerably across provinces, and that prevalence rates – in terms of this study – are highest in the Western Cape and KwaZulu Natal.

OTHER AREAS OF RESEARCH ON MSM

This section provides additional information from respondents on other research studies being conducted on MSM.

ANOVA HEALTH INSTITUTE

The Anova Health Institute has a diverse MSM focused research agenda, including work on STI's, clinical outcomes of HIV treatment, mental health issues, intimate partner violence and prevention technologies. In addition to collaborating with other South African researchers, Anova works in collaboration with a range of international institutions, including UCSF, Emory University, UCLA and the University of Cambridge on these projects.

GAUTENG DEPARTMENT OF HEALTH

The Gauteng Department of Health indicated that it was intending to implement a Behavioural Surveillance Survey (BSS) that would assess the services being offered by the Department, and the extent to which these were meeting the needs of MSM, as well as assessing the extent to which there was take-up of services. The respondent indicated that the study was "*put on hold*", but that it was hoped that there would be provision for it in the next financial year. It was reported that the Department has completed a similar BSS for sex workers.

CENTRES FOR DISEASE CONTROL

The CDC indicated that it funds a small component of what is called "Project Boithato" (described above). According to the respondent, the research components of this study, led by the University of California, San Francisco, has involved the completion of an evidenced-based evaluation .

The project's Website indicates that the Mpowerment Project is part of the Center for Disease Control and Prevention's (CDC) Diffusion of Effective Behavioural Interventions (DEBI) project, and is being replicated by CBOs across the US.

The programme is reportedly currently conducting the Translating Research into Practice (TRIP) study to review how CBOs implement Mpowerment, and Project Boithato is linked to this.

The CDC has also worked with the HSRC and the Desmond Tutu HIV Foundation on NIH funded research into combination therapy, known as the MP3 Study, implemented in Cape Town and Port Elizabeth.

The respondent indicated that in the past, the CDC also worked on a project doing viral sub-typing for HIV positive MSM in Cape Town.

DESMOND TUTU HIV FOUNDATION

The DTHF indicate that the organisation focuses on biomedical prevention trials, clinical studies and specific molecular studies.

One of these studies in which the DTHF participated was the global iPrEx study, which was a phase III clinical trial to determine whether tenofovir could safely and effectively prevent HIV acquisition through sex in MSM. The study began in 2007 at four study sites in Peru and Ecuador, following three years of extensive community and stakeholders consultations. In 2008 the study expanded to seven additional sites in Brazil, South Africa, Thailand and the United States. The DTHF was also worked with the International Rectal Microbicide Advocates to help increase awareness of microbicides, and to advocate for more clinical trials. The organization was founded in 2005 to help overcome barriers facing rectal microbicide use amongst MSM.

ECGLA

The ECGLA respondent indicated that they are running a joint project with ICAP, which involves gathering sex survey data from MSM from Nelson Mandela Bay townships. The respondent indicated that it was struggling to meet the sample quotas, however, as "*gay men don't want to come forward. It is very closeted*".

The respondent indicated that he visits the townships every week and that "*people are starting to recognise me and trust me more. Trust is the main problem*".

The respondent indicated that once the study was completed, the results would be made available.

LIFELINE DURBAN

The respondent from Lifeline indicated that they are currently conducted a research project with the Medical Research Council that involved the monitoring of all "high risk" groups. The project involves tracking return clients and monitoring their progress. The study is still in progress.

DURBAN LESBIAN AND GAY COMMUNITY AND HEALTH CENTRE

The Health Centre indicated that they had completed a mini online survey on which brands of condoms and lubricants were preferred (Choice, Mosaic or Love). The mini survey found that Love was the most popular brand, preferred because of they are viewed as "cool" and the "lube smells better". Mosaic condoms were reportedly also popular, as some are pink, and are sometimes reportedly referred to as "gay condoms". The respondent indicated further that the Choice condoms are less preferred, in part because of the perception that if they are freely and widely available, they are of a lesser quality. It was also indicated that there is a "class" issue with regards to Choice condoms, as they are seen to be "for the poor".

RESPONDENTS

Respondents from the following organisations and government departments participated in the survey:

Health Departments: National Department of Health, Departments of Health: Eastern Cape, Free State, Gauteng, KwaZulu Natal, Limpopo, North West, Western Cape. City of Cape Town.

NGO's, donors and partner organisations: AMSHER, Anova Health Institute, CDC, Diamond Gays & Lesbian Organisation, Desmond Tutu HIV Foundation, Durban Lesbian and Gay Community and Health Centre, ECGLA (The Eastern Cape Gay and Lesbian Association), FHI360, Lifeline, ICAP, HIVOS, Limpopo LGBTi Proudly Out, NACOSA, National LGBTI Health Campaign, OUT LGBTI Wellbeing, PATH, Right to Care, SANAC, SHIPP, South African Gay & Lesbian Alliance Against Defamation, Free State (SA GLAAD FS), Triangle Project, UNAIDS, WRHI

Invited to participate but not available for interview: Aurum Institute, Free State Rainbow Seeds (LGBTI), Gender Dynamix, Pietermaritzburg Gay and Lesbian Network, SWEAT, TB/HIV Care Association, USAID, UNICEF

We acknowledge the participation of the following respondents, and thank them for sharing their time and views:

Francis Akpan, Ben Brown, Thato Chidarakire, Glenn de Swardt, Pravisha Dhanapalan, Ashraf Grimwood, David Hessey, John Imrie, Karen Jennings, Benjamin Janse Van Rensburg, Dave Johnson, Thapedi Thomas Kganyago, Steve Letsike, Jacques Livingston, Nyameka Mafani, Thandazile Magubane, Pitso Maketha, Iris Mashamba, Eva Marumo, James McIntyre, John Mkandawire, Mabuti Mkangeli, Nonhlanhla Mkhize, Singilizwe Moko, Sindile Molefe, Lee Mondry, Masego Mothladi, Joel Nana, Dawie Nel, Kevin Osborne, Helen Poss, Ian Ralph, Alasdair Reid, Helen Savva, Pheello Shai, Amit Shrivastav, Nevilene Slingers, Helen Struthers, Carlos Toledo, Kobus van den Heever

4.E: GAPS, OPPORTUNITIES AND PRIORITIES

This section explores respondents' perceptions of the gaps, opportunities and priorities in terms of MSM programming and service provision.

GOVERNMENT PERCEPTIONS

Government respondents from the National DoH, as well as the Provincial Departments shared the view that the key gap in terms of the provision of services for MSM (and other defined key populations) pertained to adequate levels of staff sensitisation, and concomitant development of clinical knowledge and skills, to deal with MSM effectively at government facilities. Operating from the premise of an integrated approach for all, respondents emphasised the need for the training of staff at the level of implementation. As one respondent commented, "*I think it's [the gap] training. The implementers don't understand. We need to work together as government. It's [MSM] something that facilities are not aware of, or people are not really open about*". Another respondent reinforced this view and commented: "*when we talking about the gap, I think we need to interact and engage. They [MSM] complain about public clinics not been friendly, and attitudes are wrong. Why not work on these gaps, make sure they friendly and accessible by all?*".

In considering how such gaps could be addressed, government respondents all shared the view that whilst specialised services provided by non-governmental organisations were able to address some of the needs of MSM, these were viewed as "*expensive*" and "*not sustainable*", and that this approach could not be replicated in all areas.

Comments from different respondents in terms of the above were as follows:

- *"Specialised services (clinics) are expensive. It's better to go the general clinic, and have staff that are able to cater for all key populations"*
- *"I believe that we don't need a specialised clinic. I believe let's use what we have, and make it right so that everybody can access it"*
- *"We can't have specialised clinics everywhere. Those that can afford to go and travel and go to specialised, they can go. But not everyone can"*
- *"Setting up specific services is not the way forward. It's not sustainable and not cost effective"*.

A limited number of specialised services can provide training, research and development needs for MSM programming.

Government respondents indicated that a further gap pertained to a sufficient number or scope of initiatives to address stigma. As one respondent commented: "T*he obstacle is the issue of stigma. In the absence of policy, stigma makes these groups very vulnerable. The attitude of the health workers, some of these groups do not access the services because they fear the issue of stigmatisation. They would rather stay away*". Another respondent reiterated this view, and commented: "T*he issue is attitudes. It's traditional and cultural. It's a cultural shock. We have differing beliefs. There needs to be a process to engage society. It's a process and a commitment to dealing with that. We need to be patient and ensure we are committed as government. We need commitment from leadership and we need to create massive social mobilisation*".

One respondent suggested that an opportunity in this regard pertained to more awareness programmes at the level of the community.

Several government respondents indicated that if additional funding was to be made available for service provision in MSM, prevention would be the best area of focus and, in particular, combination prevention. One respondent indicated that there was a glut of funding for treatment, but prevention required more focus. As one respondent commented, "*a lot of funders are focusing on the treatment, but we need to do more on prevention. We need to look at this more. You can never ignore this. Through prevention, we will ultimately reduce the budget for treatment*". Another respondent indicated that "*there is always less money on prevention. Now more money is spent on ARVs. We need to focus on prevention – that's where the gap is*".

Another respondent commented that specific gaps in terms of prevention included the provision of condoms and lubricants that were attractive to MSM. Another respondent indicated that while government had paid attention to the provision of condoms, the need to distribute lubricants for MSM at a national level was a priority.

Another respondent reported further that there was a need to improve "*prevention messaging, and adjusting this messaging to fit the MSM population in terms of lingo and community norms*". Another respondent supported this view, and reported that a key opportunity would be "*communication and prevention messaging for MSM*".

One respondent indicated that there was an emerging need to review the opportunities in terms of PrEP and ART as prevention, but that it was "*early days*" for government to consider these measures, although external agencies could potentially consider this as an opportunity. A National DoH respondent indicated that there was "*a lot of talk about PrEP*", but that this was not presently a government policy, and would likely not receive attention from the government in the short and medium term.

NON GOVERNMENTAL PERCEPTIONS

This section reviews the perceptions in terms of gaps, opportunities and priorities of the non-governmental organisations interviewed for these purposes, including donors and umbrella organisations. The data has been analysed thematically according to the emerging responses.

DATA AND RESEARCH

One of the key areas identified as a gap by respondents (and this is referred to elsewhere in this report) pertains to comprehensive and national information on MSM. Respondents report that data on MSM, including data on HIV prevalence and incidence, is sketchy and piecemeal, and has not, to date, been able to provide a comprehensive picture of MSM in South Africa.

Respondents indicate that a comprehensive body of data is urgently required, both to inform policy, as well as programming. Responses included:

- *"We need to get a clearer sense of what happens here. How deep and how wide. And on that basis we then need to identify gaps and then review how to fill them" –*
- *"One of the key things is to get a decent survey up and running. Until we have a better idea of how many MSM there are, where they are and how receptive they are to the various sorts of programming, we risk wasting a lot of money. For example, much of MSM programming is aimed at black men in townships. There are a significant number of middle class MSM who are not being reached. They are largely ignorant, may not be 'out', but are relatively easy to reach*
- *"There is data that exists, but it is not sufficient. We need this data in the form of operational research to inform policy"*
- *"The major gap is the lack of evidence, of data, around MSM. There have been some smaller studies done but no national work"*

In addition to data to inform policy and programming, respondents also indicated that there was a need for this data as a baseline against which to monitor prevalence, incidence and provision. As a respondent from FHI360 commented, "*there is currently no MSM denominator and then we need to decide how many people we need to reach to make a sizeable impact and then we need to monitor this*".

A COORDINATED NATIONAL RESPONSE

The second theme emerging in terms of perceptions of gaps, opportunities and priorities pertains to perceptions of the need to strengthen a coordinated, national response to MSM and HIV.

Responses suggest that the two core issues pertaining to a coordinated national response relate to (i) reducing duplication and increasing cooperation and (ii) extending service provision and support services across the country, and beyond the current concentrations in selected urban areas.

A respondent indicated that there was a strong need for partnership, but that the current situation was such that "*partnerships are still a difficulty that we need to sort out to avoid overlaps. There are lots of us doing this work, but we not speaking to each other to maximize the reach*".

Another respondent commented, "*We need a decent national strategy, and a national presence around MSM, where all of the activities of the various providers can be co-ordinated. We also need a website which talks about all the information and services which are out there. People need to be able to access accurate information, including in the rural areas*".

Both respondents from SANAC echoed this view:

"It [MSM programming] needs direction and co-ordination to pull everybody together and to say what is needed. And I think SANAC is the structure that is meant to do that, bring all of that together. There needs to be a delicate working together when you're working with government and civil society. When government do it on their own, it's a one-way relationship and that doesn't work".

"There needs to be coherent partnership. That's a huge gap. Even the small organisations that exist. There isn't a coherent partnership".

One respondent indicated that one of the challenges relating to coordination pertained to a lack of funding in the sector, and the concomitant competition for resources. Two respondents suggested that one of the challenges was that larger organisations tended to receive the lion's share of funding for MSM, and that community programming, which was viewed as critical to succeed in terms of national reach, receives very little of the funding pool in this regard. As one respondent commented, "*One needs to increase the funding to community structures and to community practice. This is critical*".

While SANAC views this coordination as its responsibility, a respondent from UNAIDS indicated that they were also starting to work with the Provincial AIDS Councils to look at "sustainable ways of taking forward programming around key populations".

CONSIDERING SPECIALISED FACILITIES

As evidenced in the previous section, government respondents support a view that widespread specialised MSM clinics in the public sector are not a feasible option, although data from this assessment strongly suggests that the support provided in the form of specialised MSM centres by external organisations is significantly valued.

Several non-governmental respondents agreed with the view that standalone public sector MSM facilities would not be feasible, but one respondent suggested that increasing the numbers of male wellness clinics could be viable. The respondent suggested that, for example, several organisations are currently running Medical Male Circumcision (MMC) clinics, and that, in time, the need for these services would be reduced, potentially creating the space for a focus on male wellness clinics instead. The respondent suggested further that these could also target other key populations, such as sex workers.

COMBATING STIGMA

As with the Department of Health responses to gaps and priorities, several respondents indicated that a significant area of priority was reducing stigma, both at the level of communities at large, as well as in terms of health care providers.

In terms of health care providers, one respondent indicated that "*we need to ensure that service providers are informed about everything and understand, for example, that condoms go with lube. There is a real need for the sensitization of service providers*".

A respondent from one of the organisations, which is presently rolling out sensitisation training for the DoH in selected provinces, indicated that "*the majority of participants are receptive to the training, but it's difficult to assess. We have seen real shifts when we do the mentoring, but we have only been able to roll this out to three facilities per province*".

Another respondent made a distinction between "sensitisation" to MSM and issues pertaining to stigma and attitudes. The respondent questioned the extent to which stigma and attitudes could be easily changed in a "*health system that is under stress*". The respondent indicated that changing attitudes was "*more complicated*" and would take dedication, coordination and time.

Other respondents spoke to the need to reduce stigma at a community level, and the need to support interventions that can assist MSM to disclose their sexuality as MSM, and to seek appropriate treatment, care and support. A respondent indicated that "*MSM are a hard to reach population. There are issues around disclosure and the shame of admitting having sex with another man*". This respondent gave the example of the "*amazing success*" with a Project Boithato (described previously)

event in Piet Retief on 8 September 2013, where about 500 community members attended a function in support of men who had come out.

Another respondent indicated that there was a need for national awareness raising campaigns, and another indicated that there was a need to "*literally drop information out from planes to get it out there*".

PREVENTION

The penultimate gap and opportunity emerging from the interviews pertained to prevention. As with government respondents, several non-government respondents indicated that prevention (including combination prevention) was a gap in many areas and that there was a critical need for prevention initiatives to be expanded.

Specifically, several respondents suggested the need for packages of condoms and lubricants that were branded for MSM. This issue has already been addressed in other sections of this report, but respondents reiterated that MSM tend not to like the Choice condoms and a respondent suggested the need for a "*major campaign and widespread distribution of male and female condoms and lube*". Another respondent indicated that "*without lubricants, condoms will not be utilised, or the use thereof will be rendered ineffective. I am of the view that lubricants must be made as readily available as condoms*". The successful distribution of branded condoms and lubricant targeting MSM, such as Helath4Men and MOSAIC have instituted, supports these views.

A respondent suggested that there was a need for increased emphasis on considering behaviour change as a component of combination prevention. The respondent indicated, for example, that issues of alcohol and substance abuse appear to be a significant problem amongst MSM, and that paying greater attention to psychosocial issues such as substance abuse is an area that requires greater prioritisation.

Finally, some respondents spoke to opportunities in terms of PrEP. The CDC indicated that while it was not a national programme, there was a strong need for looking at the role of treatment as prevention. Several respondents indicated that PrEP was an area of potential increased focus for MSM, and highlighted an urgent need for pilot projects to better understand how to deliver PrEP.

SPECIFIC MSM GROUPINGS

Some respondents made specific reference to sub-groups of MSM that require attention.

For example, a respondent suggested that there was a need to consider older MSM populations, and why there appeared to be increasing risk amongst this sub-group. It was suggested that there needed to be a consideration on what had changed that had resulted in increased risk amongst older men, and what needed to be put in place to address this.

Further, a private practitioner suggested that whilst much MSM programming focused on younger men, it was his perception that young men of school-going age were not adequately addressed, and that the focus was rather on young men in late adolescence and early adulthood.

The respondent suggested that young men of school going age were an important target in terms of prevention, as schools generally did not prioritise the provision of support for MSM, at a time when young men were likely to experiment sexually without sufficient knowledge of prevention strategies and with concomitant risks to their health.

There remains a need for specific transgender programming, which acknowledges that the needs of this group may differ from those of MSM.

Finally, male sex workers – as a sub-group of MSM – required further prioritisation.

4.F: SUMMARY OF FINDINGS

This section provides a discussion on the key findings emerging in the course of this assessment, including perceptions of MSM policies and guidelines, a review of overall MSM programming and service provision, and a consideration of data emerging with regards to gaps, opportunities and priorities.

MSM POLICIES AND GUIDELINES

Overall, this assessment has found that respondents are optimistic that the Operational Guidelines on Key Populations will provide the basis for improved programming and an appropriate level of focus on MSM and other key populations as a priority. The Operational Guidelines are viewed as both relevant and comprehensive.

Some concerns were raised in the course of this assessment about the challenges that are likely to be faced in the implementation of the guidelines, including the pace of implementation, and the extent to which they will filter down to the district, sub district and facility levels. Further, there is some concern about the extent to which issues of stigma will impact on implementation.

Respondents were also asked to indicate if they were aware of any other non-governmental guideline documents available for MSM and HIV. Those identified include guidelines for sensitisation training, as well as guidelines for healthcare workers. In addition, quality assurance standards for per educators for key populations (i.e. the Quality Assurance Standards Compendium") have been developed, and will reportedly be available by the end of 2013.

Finally, the Southern Africa HIV Clinicians Society had compiled Pre-Exposure Prophylaxis (PrEP) guidelines for MSM. These are published in the Southern African Journal of HIV Medicine, June 2012, Issue 44, Vol. 13, No. 2, and are available on the Society's Website (www.sahivsoc.org). A SANAC respondent indicated that it was anticipated that PrEP would become a key focus in the new round of GF funding for MSM.

MSM AND HIV SERVICES AND PROGRAMMES

GOVERNMENTAL SERVICE PROVISION

The South African Government's (SAG) approach to MSM service provision supports integrated service delivery to all, including MSM and other identified key populations. As such, emphasis is placed on ensuring that healthcare workers and facilities at the coalface of primary health care are equipped to provide MSM with appropriate services. This is to be achieved through sensitisation training, as well as concomitant clinical training and mentoring to support MSM and other "key populations".

While interviews with several government respondents emphasised the need for increased sensitisation and related training for healthcare workers, the data emerging in this assessment suggests that there is substantial activity in this regard, both in terms of current training, as well as planned training pertaining to increasing healthcare workers' competence for MSM. Current coverage of this training and mentoring (as reported by respondents in this assessment) is presently being rolled out by organisations such as ICAP and the Anova Health Institute. Between the two institutions, training is planned in all nine provinces. For ICAP, these include the Eastern Cape, Free State, KwaZulu Natal, Limpopo and Northern Cape. For Anova, these include Western Cape, Limpopo, Mpumalanga, Gauteng, North West, Free State, Eastern Cape, Northern Cape and KwaZulu Natal to facilitate an integrated national coverage addressing HIV among MSM.

NON-GOVERNMENTAL SERVICE PROVISION

The findings of this assessment suggest that service provision tends to be concentrated in Johannesburg, Pretoria, Cape Town and Durban, with isolated scatterings of provision in other areas, primarily through Anova's work in other provinces and the ICAP Mosaic initiative. Further, the findings indicate that the largest portion of programming is in combination prevention and HCT, with only seven centres countrywide providing holistic services for MSM, including treatment (six of these are Health4Men initiatives and the remaining site is the OUT clinic in Pretoria).

The findings indicate that the largest current implementing organisations in terms of non-governmental services for MSM are the Anova Health Institute (through the Health4Men initiative), as well as the ICAP Mosaic initiative, which employs a "community of practice" approach to combination prevention. This involves bringing identified NGOs in a particular area together, and then allocating responsibility for various aspects of the programme to these organisations, in accordance with their areas of expertise.

While several smaller provincially based MSM programmes and services are available (some of which operate under the auspices of Mosaic), the findings suggest that many of these smaller NGOs are under-funded and, as suggested by one respondent, tend not to be sufficiently organisationally robust and coordinated.

Within the above context, however, the assessment notes the impending finalisation of additional funding from the Global Fund for MSM programmes and services that, in addition to further support in terms of DoH sensitisation and clinical training, will include a focus on prevention services for key populations, including the university programme that will be supported by NACOSA. Of significance in terms of the GF funding is the finding that that previous GF funding for MSM had been in the region of approximately $500 000. It was indicated that this has now been increased to approximately $11 million (although allocations have not yet been finalised).

A final component of provision for services for MSM pertains to the private sector. Private sector respondents indicated that services for MSM are available at select private practices for those who have access to medical aid or other personal funding for private health care. The respondents suggest, however, that this provision is piecemeal and based on "word of mouth" and that the sector would benefit from greater levels of coordination and/or communities of practice around MSM. Further, there is a perception that current private provision for MSM is possibly on the wane as a result of high levels of practitioner emigration, and changes in the accessibility of ARVs in public facilities.

RESEARCH ON MSM AND HIV

RESEARCH ON MSM HIV INCIDENCE AND PREVALENCE

The findings of this assessment indicate that data on MSM in terms of HIV prevalence and incidence is piecemeal and limited, and that no comprehensive national picture in this regard exists at present.

Government respondents proposed that public facilities do not collect data that allows disaggregation by key populations, although it is understood that there are discussions underway to review this.

Outside of government data, the key studies on incidence and prevalence cited are the JEMS study, the Soweto Men's Study and the DTHF and Johns Hopkins behavioural and prevalence assessment based on Cape Town data

Additional research results from Tshwane and Mpumalanga will be available in the coming months and the HSRC national data , and MSM study, will add to the available evidence. Further surveillance work will be undertaken in 2014.

Other Areas of Research on MSM

A small number of respondents indicated that they were involved in the completion of additional studies in MSM. These included the MPowerment study (Project Boithato), a collaboration between UCSF and Anova. The CDC also worked on a project doing viral sub-typing for HIV positive MSM in Cape Town.

The Anova Health Institute has a diverse MSM focused research agenda, including work on STI's, clinical outcomes of HIV treatment, mental health issues, and intimate partner violence and prevention technologies. In addition to collaborating with other South African researchers, Anova works in collaboration with a range of international institutions, including UCSF, Emory University, UCLA and University of Cambridge on these projects.

The Desmond Tutu HIV Foundation is working with the HSRC and Johns Hopkins on NIH and CDC funded research into combination therapy, known as the MP3 Study, implemented in Cape Town and Port Elizabeth. DTHF is also working on rectal microbicide research.

Further, the ECGLA are running a joint project with ICAP, which involves gathering sex survey data from MSM from Nelson Mandela Bay, and Lifeline Durban are currently conducted a research project with the Medical Research Council that involved the monitoring of all "high risk" groups. The project involves tracking return clients and monitoring their progress. The Durban Lesbian and Gay Community Health Centre also reportedly completed an online survey on condom preference.

Gaps, Opportunities and Priorities

Government Perceptions

Government respondents from the National DoH, as well as the Provincial Departments shared the view that the key gap in terms of the provision of services for MSM (and other defined key populations) pertained to adequate levels of staff sensitisation, and concomitant development of clinical knowledge and skills, to deal with MSM effectively at government facilities.

Government respondents indicated that a further gap pertained to a sufficient number or scale of initiatives to address stigma. One respondent suggested that an opportunity in this regard pertained to more awareness programmes at the level of the community.

Several government respondents indicated that if additional funding was to be made available for service provision in MSM, prevention would be the best area of focus and, in particular, combination prevention. Specific gaps in terms of prevention included the provision of condoms and lubricants that were attractive to MSM; the inclusion of lubricant in condom packages for MSM; the improvement of prevention messaging to MSM and PrEP (although noting that this was not a government priority, this represented an opportunity for external agencies).

NON GOVERNMENTAL PERCEPTIONS

Key gaps, opportunities and priorities for non-governmental respondents included:

DATA AND RESEARCH

One of the key areas identified as a gap by respondents pertains to comprehensive and national information on MSM. Respondents report that data on MSM, including data on HIV prevalence and incidence, is sketchy and piecemeal, and has not, to date, been able to provide a comprehensive picture of MSM in South Africa.

In addition to data to inform policy and programming, respondents also indicated that there was a need for this data as a baseline against which to monitor prevalence, incidence and service provision.

A COORDINATED NATIONAL RESPONSE

The second theme emerging in terms of perceptions of gaps, opportunities and priorities pertains to perceptions of the need to strengthen a coordinated, national response to MSM and HIV.

Responses suggest that the two core issues pertaining to a coordinated national response pertain to (i) reducing duplication and increasing cooperation and (ii) extending service provision and support services across the country, and beyond the current concentrations in selected urban areas.

CONSIDERING SPECIALISED FACILITIES

Government respondents support a view that widespread specialised MSM clinics in the public sector are not a feasible option, although data from this assessment strongly suggests that the support provided in the form of specialised MSM centres by external organisations is significantly valued. The current focus on training for "clinical competency" in MSM care across health services is an appropriate response.

COMBATING STIGMA

As with the Department of Health's responses to gaps and priorities, several respondents indicated that a significant area of priority was reducing stigma, both at the level of communities at large, as well as among health care providers.

PREVENTION

As with government respondents, several non-government respondents indicated that prevention (and notably combination prevention) was a gap in many areas and that there was a critical need for prevention initiatives to be expanded.

Specifically, several respondents suggested the need for packages of condoms and lubricants that were branded for MSM. Others suggested the need for increased emphasis on considering behaviour change as a component of combination prevention, including issues pertaining to alcohol and substance abuse.

Finally, some respondents spoke to opportunities in terms of PrEP. There is also a definite need to look at optimizing the role of treatment as prevention.

SPECIFIC MSM GROUPINGS

Finally, some respondents made specific reference to sub-groups of MSM that require attention. These include both older and young MSM, male sex workers and transgender people.

The needs of MSM accessing private health care, both in ensuring appropriate care and in accessing health information should also be considered.

PART 5:
MSM PROGRAMMING IN SOUTH AFRICA PRIORITY ACTIONS

SUMMARY PRIORITY RECOMMENDATIONS

POLICY

There have been significant advances in policy development and implementation for MSM and other key populations in South Africa. Following on from the current National Strategic Plan (NSP), which acknowledges MSM as a key population, several current initiatives are advancing MSM work.

- Although not yet fully released, there is widespread support for the Key Populations Operational Guidelines for the health sector. Once finally signed off and published, the next challenge will be to disseminate and promote the final guidlines to the provinces.

- Few provinces have yet developed their own guidelines or polices for MSM. Although national guidelines are set, provinces have a great deal of autonomy in implementing health services, and in developing provincial policies. Support for this process fits well in the mandate of SANAC, working with provincial AIDS Councils, and with the SANAC LGBTI sector. The gaps in provincial policies provide an opportunity to support and work with SANAC and others to ensure provincial policy development and implementation. Additional support to the existing technical partners and the sector organisations could help accelerate the provincial policy processes, and contribute the necessary technical expertise.

- The draft Department of Health HIV prevention policy is a wider scope document, but it will also provide a framework to extend MSM prevention activities within the health sector. Similar issues in dissemination and provincial implementation apply.

- New thinking and consultation on the government's Condom Policy could provide an opportunity to reconsider branding and distribution of condoms and lubricant targeted at MSM communities.

- The SANAC LGBTI sector has put forward priorities for action that are well aligned to the stakeholder suggestions and recommendations of this report. The coordination role of the LGBTI sector has some funding and support from SANAC, and can be further extended and harnessed in future. Although it is

not a legal entity or an implementing organisation, the LGBTI Sector can be influential in fostering collaborative work.

- There is an urgent need to obtain better estimates of MSM population size and mapping of communities, MSM resources and outreach target areas, is needed in order to optimize interventions. The recent sex worker population size estimate exercise has more clearly defined the scale of need and enabled decisions on where to target services. In order to move from policy guidance to implementation, a similar level of knowledge is required for MSM. The current government identified High Transmission Areas, in which other key populations are targeted, may or may not be the highest areas of need for MSM. There is some research work planned for 2014 on population size estimation, and provision for mapping of MSM communities in four provinces in the anticipated Global Fund MSM support. Additional resources for more community mapping activities in both rural and urban areas in all provinces in the next year could greatly assist in this process, and in linking to the care and treatment services that are being established.

CARE & TREATMENT

Important advances have been made in extending competency in MSM care within the government health services, although the need for further extension is great. Health service stigma remains a major barrier to access to clinical services for both prevention and care and treatment for MSM. The balance between integrated services for MSM and other key populations at facility level and the continued need for MSM-appropriate and targeted information and outreach services needs to be acknowledged and implemented.

CLINICAL SERVICES:

Development of health service capacity must be accompanied by targeted information and outreach activities to increase the number of MSM who know their HIV status, have access to prevention technologies and access treatment and care at an appropriate time.

- There is consensus that Primary Heath Care facilities should be able to provide sensitive and competent services to MSM across the country. The Key Populations guidance recognises that staff in these facilities need to understand issues and be able to deliver service for multiple groups, and that training can be designed to improve skills for several key populations.
- Current PEPFAR support, through the USAID-supported Anova Health4Men programme, and the CDC-supported ICAP mosaic programme has enabled

excellent progress in extending MSM competency training to facility level. Together with the work in the anticipated Global Fund award, and the pilot phase of the integrated Key Populations training, these programmes should reach over 200 facilities by the end of 2014. Although this is a limited scale in national terms, it appears to be the maximum extension rate with available funding. More information on population mapping could help to determine the optimal choice of facilities, and assist in measuring access. Additional resources would be best used to extend current approaches, in collaboration with provincial health departments.

- While dedicated MSM services will not be required in all facilities or towns, there is a need to foster expertise in MSM care and investigate innovative models of care and delivery of biomedical prevention modalities. These experienced staff will also be the core trainers and mentors to ensure wider rollout of MSM competency to primary care level, and to build long term sustainability. Consideration should be given to expanding Anova's current Centres of Excellence approach, which is established in Cape Town and Johannesburg, to other major provincial centres.

- There is also a need to consider and develop pre-service training approaches for health workers (both doctors and nurses). Activities to date have been limited to some academic centres, but could be expanded through further discussion with training institutions and dissemination of resource materials.

- MSM who access care in the private health sector remain a hard to reach and underserved group, but may constitute a relatively large number of men, who also experience stigma, discrimination and lack of services. South Africa has a dual health system with a large private health sector, funded by individual and medical insurance schemes and a state funded health sector. While 70% of South Africans rely on state services for all health care, around 30% use private medical practitioners and services. Plans for a National Health Insurance scheme may increase the proportion using private sector providers in the future, but also more closely link these to the state sector facilities. More than 60% of doctors in South Africa work in the private sector. While efforts are being made within the state sector, there has been no parallel process to serve the needs of many MSM who do not use State facilities, especially employed MSM or those covered by health insurance who utilise general practitioners or private sector facilities. There is a need to educate providers and to reach these men. Support for formative work in this regard is under consideration by a private foundation donor, but additional support will be required to implement such programming at scale.

- There has been a lack of mainstream and explicit HIV prevention campaigns targeting MSM risk behaviours and of MSM targeted awareness campaigns

about HIV testing, STI treatment and HIV treatment for middle and higher-level socio economic groups. Several respondents in this assessment identified the lack of campaigns targeted outside of state facilities and township clinics, and the dearth of education and awareness in providers of healthcare outside of the state health systems, which results in sub-standard care for MSM within the private sector.

- Alternative treatment delivery strategies for the MSM community should be considered in areas of high MSM populations. Approaches for community delivery of ART are gaining support in many areas, and "shop front" or community centre located services could provide prevention, testing and treatment while taking some of the chronic HIV case load out of busy health centres.

ANTIRETROVIRAL TREATMENT

There is little information on the proportion of South African MSM who are receiving antiretroviral treatment, or on the "cascade" of care.

- More work is needed to evaluate and optimize treatment approaches and strategies. This includes antiretroviral treatment, sexually transmitted infections in MSM and mental health assessment and care.

- MSM-targeted treatment information and retention and adherence support strategies, which take into account the situations of diverse MSM, have not been implemented in South Africa. Support to develop these, including linking to and adapting international web based and mobile phone approaches (similar to those developed by the Terence Higgins Trust) could be a very important area of support.

SPECIAL GROUPS

MSM is a broad behavioural category, including men who identify as heterosexual, homosexual, and bisexual as well as biologically male transgender or gender queer individuals. Additionally, MSM may be at additional risk for HIV through sex work or drug use, and these sub groups may require additional service support.

- Services for transgender people may need additional skills and more intensive sensitisation of health workers. GenderDynamix has led the way in producing some guidance on this, which has now also been reprinted for wider distribution by Anova. There needs to be more discussion and planning on

how and where more specialised transgender expertise can be developed and appropriate services provided.

- MSM sex workers may require additional care, STI screening and treatment. Integrated key populations training can help to build competency for this, but additional service and targeted outreach may be important for this group. The National Sex Worker Programme in development is currently more focused on female sex workers, although it includes male sex work in its scope. Additional targeted MSM sex worker support could contribute to this community.

PREVENTION

MSM in South Africa are an under-served group in terms of HIV prevention. In addition to comprising multiple gender identities and sexual orientations, MSM in South Africa are also differentiated along racial, age, and socio-economic lines. There has been a lack of MSM targeted prevention or treatment information campaigns across all of these groups. Mainstream prevention messaging does not explicitly address high-risk activities for MSM, in particular the risks of unprotected anal intercourse.

Respondents to this assessment acknowledged the considerably increased levels of funding and support which have enabled MSM treatment service delivery to be extended, but rank additional support for HIV prevention for MSM as a major priority need.

Strategic investment in MSM targeted prevention and treatment information would complement the existing support for treatment efforts and could be the most important new contribution to the field.

Government funded activities, both by the South African government structures and international donors, are often subject to more political constraints in terms of MSM-themed and, in particular, explicit messaging which directly addresses the drivers of MSM risk. Foundation funding may allow more effective innovative approaches.

PREVENTION MESSAGING AND COMMUNICATION

- There is a need for expanded HIV prevention messaging for MSM, which can be widely distributed and accessed by MSM across the country. A coordinated messaging campaign should also address nuanced messaging for diverse groups of men, potentially under an overarching brand umbrella that can maximise reach.

- The use of social media and electronic communication, in particular mobile phone communication, allows for both information dissemination and interactive content in private. Existing project mobile phone projects will be further extended by activities in the new Global Fund supported grant, and the extensive programme infrastructure which be established will also allow for addition of linked sites with potential to reach local groups or targeted age group or sexual practice groupings.
- There is a need for exploration of communication strategies targeted at young MSM, which can combine information and prevention access with approaches to address structural issues, "coming out" and build self-esteem. While similar approaches are being implemented targeting young women, using socially aspirational content to encourage access and direction to HIV material (such as HIVSA's *Hi4LIFE* and *Choma* projects), this has not been attempted for young MSM.
- There is a need to consider some scale of explicit messaging for high risk sexual activity groups, including MSM who use drugs and those involved in "hard core" sexual practices, who may be hard to reach with more mainline messaging.. Recognising the potential high transmission impact of these groups, International examples of these programmes have used sign-up or membership approaches to control access to the preventions strategies.

CONDOMS AND LUBRICANT

- While supply of standard Government issue condoms has been increased in recent years, there has been very little supply of lubricant for MSM other than through NGO's. There are also widespread negative perceptions about the "Choice" brand of condoms supplied by the Department of Health. There is an opportunity to focus an MSM-targeted brand of condom and lubricant to be supplied for MSM, and consideration should be given to building on one of the successful NGO brands to include this in government or PEPFAR funded supply, for use in MSM programming to increase condom use.

BIOMEDICAL PREVENTION

- With an increased focus in "Treatment as Prevention" more intensive efforts must be made to seek, find and retain MSM in care and treatment. Outreach testing needs to be increased, and capacity building and support of MSM civil society organizations, in addition to building facility capacity, could

achieve this. More discussion is needed on suggestions to allow treatment at an earlier stage for MSM (higher CD4 count or approaching a test and treat strategy), acknowledging the higher risks of transmission in this group.

- More implementation is needed for "Combination Prevention" approaches, including understanding and delivering multiple prevention strategies or providing a menu of prevention options that are easily accessible for MSM. With treatment being the major focus in overburdened health services, there should be urgent consideration of ways to pilot combination prevention provision outside of health services, while linking closely to care.
- The NSP envisages pilot projects of PrEP and other new biomedical approaches as these become proven and available. Although PrEP guidelines have been issued by the SA HIV Clinician's Society, there has been minimal progress in implementing the strategy. Consideration should be given to PrEP demonstration sites in the next year to understand whether this could be a feasible, acceptable and effective prevention strategy.

CIVIL SOCIETY AND STRUCTURAL INTERVENTIONS

There is recognition of the need to reach diverse groups of MSM in communities and to provide support on multiple levels. Structural interventions to raise the social capital of MSM and address stigma remain crucial to the success of HIV prevention or treatment programming.

- The network of MSM civil society organisations remains thinly dispersed across the country and these are not large or well organised enough in many areas to make a major impact. The work of the SANAC LGBTI sector in bringing together these groups and encouraging new groups is crucial to expanding civil society support, and should be extended. Consideration must be given to how these groups can also focus on HIV prevention and care access issues without losing the essential human rights advocacy work. Capacity building of civil society organisations to enable good governance, compliance with grant awards and successful administration will be crucial to any expansion. Linking smaller civil society groups to larger scale prevention programmes for supply of information materials, condoms and lubricant and communication systems would help to build capacity and avoid the need for duplication.

Limited examples of structural community base programmes are showing promising results (for example, Anova's *Ukwazana* and UCSF's*Project Boithato*). Funding for extension of such approaches may be is difficult through the existing funding channels but new options should be explored.

MOVING FORWARD WITH PRIORITY ACTIONS

The results of this assessment provide encouraging evidence of **an up scaling of both interest and activity in HIV programming for MSM**. A supportive policy environment, unique in Africa, exists with commitment by SANAC and the South African government. An unprecedented level of international donor support, led by PEPFAR and the Global Fund is increasing access to HIV testing care and treatment, and current and planned projects are starting to extend this outside of the main urban centres and into more rural parts of all provinces.

There is widespread support for an approach that integrates MSM competent services into primary health care, with the caveat that there is little hard evidence or experience yet that this will be fully successful in addressing the barriers to health care for MSM. While further support for care and treatment could increase the pace of capacity development and further expand access, this would require additional resources, staffing and technical assistance, which may best be provided through existing donors and local agencies than by establishing new approaches.

There is however a need to address **gaps in the care and treatment programming,** and some possible innovations. Three areas of need are priorities: addressing MSM competency for health workers in the private sector; addressing clinical care skills for transgender people and investigating alternative community based delivery approaches for chronic HIV treatment for MSM in areas of high MSM prevalence, to relieve some of the burden on health facilities whilst ensuring prevention and MSM information provision.

HIV prevention is identified as a priority for further support. There are challenges in aligning and ensuring a dual strategy for prevention and care, promoting an integrated care system, whilst acknowledging and addressing all of the multiple issues which make MSM a key population at high risk for HIV. Prevention interventions, across the spectrum from information and behaviour change interventions to the provision of biomedical strategies, must target diverse groups of men in ways that are appropriate for them.

Whilst government and bilateral donor funds can support health system interventions very effectively, prevention interventions sometimes need to be more explicit and more innovative than is possible with state funding. Private foundation support is well suited to be able to target hard to reach populations and to move rapidly and effectively to innovate in this field, for example with targeted media campaigns.

Support to civil society organisations and structural interventions are important in reaching MSM and linking them to HIV prevention and care. Additional support for these approaches will be needed to optimize the reach of MSM programming.

The progress to date in building MSM services in South Africa provides a unique foundation to redouble efforts now, to ensure that the progress to an AIDS-free generation includes MSM.

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