

# HATiP

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# Appropriate prevention and care services for men who have sex with men and transgender people in resource-limited settings

By Theo Smart

*"In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us."*

**Ban Ki-moon, Secretary-General of the United Nations, World AIDS Conference, Mexico City, 2008**

Hidden or ignored HIV epidemics among men who have sex with men (MSM) and transgender people are spreading rapidly in many low and middle income countries, according to a growing number of studies (detailed below) including some conducted in parts of the world where such data previously did not exist, including sub-Saharan Africa, Asia, and the Middle East and North Africa (MENA) region.

"These epidemics are ubiquitous and severe," said Dr Carlos Fernandez Cáceres, Director of Research at the Peruvian Network for Education, Sexual Health and Development of Young People at the opening plenary at this year's Conference on Retroviruses and Opportunistic Infections (CROI). Dr Cáceres has authored several studies on calculating the number of men who have sex with men in low and middle-income countries — and his talk at CROI provides much of the material for this article. "Furthermore, there is a growing consciousness that social exclusion of MSM limits access to prevention and care... At present UNAIDS and the WHO estimate that less than 10% of MSM in low and middle income countries have access to HIV prevention and care," he said.

Sex between men has been an important mode of HIV transmission since the infection was first observed over 25 years ago, and the HIV epidemics in many industrialised countries are predominately or significantly located in men who have sex with men.

But many countries, where sexual activity between men or with a transgender person remains illegal or taboo, have long denied the existence of MSM among their populations or describe same-sexual activity as an imported 'Western vice'. MSM and transgender people are so reviled in some cultures and their environment so oppressive, that many prefer to remain hidden even when gravely ill, given the risks of rejection, violence or blackmail by healthcare workers, friends, neighbours and family, and, in some settings, the fear of being incarcerated or even put to death. This makes it much more difficult to come by reliable data on the size of this marginalised population and their burden of HIV.

Consequently —and also because of wilful neglect— "the commitment and resources allocated to HIV services for men who

have sex with men (MSM) and transgender people fall far short of what is required to achieve universal access to appropriate HIV prevention, treatment, care and support services across the world," according to the recently published *UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People*.<sup>1</sup>

Failure to acknowledge the epidemic of MSM and transgender people has allowed the disease to spread among this population and is beginning to increase the pressure on health services for treatment.

"We have failed to bring down the incidence among MSM because, with some exceptions, we have not tried" said Jorge Saavedra, from Mexico's Centro Nacional para la Prevención y Control del VIH/SIDA (CENSIDA) said at the World AIDS Conference.

The UNAIDS Framework (which will help direct UN agency action on this issue) states that "addressing the HIV epidemic among marginalized groups is not just important in and of itself; it is often one of the most effective strategies to reduce heterosexual spousal transmission and avert larger heterosexual epidemics." In other words, many MSM are in bisexual relationships — and without effective prevention services, there is the potential for an unmanaged epidemic among MSM that could lead to more transmission to the general population. Likewise, where MSM and injection drug-using overlap, failure to address HIV in one concentrated epidemic affects the other.

Importantly, however, the UNAIDS document stresses that regardless of one's personal belief or bias, *everyone* "including men who have sex with men and transgender people, have the right to the highest attainable standard of health, non-discrimination and equality before the law, and freedom of expression and association, among others."

As the UNAIDS Framework demonstrates, there is a growing emphasis on addressing the HIV-related needs of MSM and transgender people among international technical agencies, and multilateral, bilateral and private donors (including notably the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). International and local advocacy is also increasingly challenging laws, attitudes and behaviour that limit access of MSM and transgender people to essential health services. And potentially, in a climate where donor funding for HIV services is not guaranteed, it may be harder to justify supporting national programmes that do not to provide equitable access to health services to *all* its citizens.

But programmes and healthcare providers that want to provide non-judgmental access to care and services may still face a number of challenges, including identifying of the local MSM and transgender population, assessing its healthcare needs, earning its trust, and designing and delivering appropriate services and interventions. However, a growing number of implementers and organisations are beginning to share experiences on this front.

## Difficulties studying HIV in MSM and transgender people

"We have more information [about MSM and HIV] but remain far from knowing what we need to know especially in Africa, Eastern Europe and the MENA region," said Dr Cáceres. "And the existing information is far from being of ideal quality."

As already noted, criminalisation and prejudice make it difficult to study this population. Not only are MSM not included in the routine national HIV surveillance, governments often try to discourage independent research. For instance, government officials in Togo told a research team in Togo not to bother with

looking for MSM in that country because they did not exist.<sup>2</sup> However, a small study went on to identify at least 122 MSM in one locality, about 47% of whom are married and also have sex with women or girls — so clearly there is a need for appropriate prevention services.

Dr Cáceres also noted that research is often limited because culture and behavioural categories of MSM and transgenders are often poorly understood when a study begins. “Survey research has to be direct, and hence, fails to be nuanced enough. For example, something as simple as asking about sex between men, fails to recognize that [in many cultures], having sex is something that men can only do with women. Sexual activity with other men is called something different.”

For instance, [a 2005 study in AIDS](#) described how traditional Western ideas of what constitutes sex between men do not often correlate with the Asian experience.<sup>3</sup> The study reported that in Thai culture there are three genders: male, female and Katoey: the latter are males who adopt female names, roles, and identities, and are perceived as a second category of women. Men who have sex with transgender persons known as Katoey, do not perceive themselves —and are not perceived by others in Thailand — to be engaging in sex between men, and consequently require culturally appropriate targeted prevention.

This raises another issue — that the term MSM itself is somewhat problematic. It was coined in an attempt to encompass non-gay-identified men who have sex with men and to describe their HIV risk — although increasingly, studies show that the risks of HIV infection vary with sexual role (receptive or insertive) and whether the man identifies himself as gay or homosexual. Some surveys categorise transgender people (who were assigned a male identity at birth, but who now identify as female or exhibit predominantly female characteristics) as MSM. But according to Dr Cáceres, “it is increasingly inappropriate to include male-to-female transgenders in the MSM category since they are evolving as a separate group identity and do not accept to be conflated with MSM.”

Notably, studies suggest that transgender people are even more vulnerable to HIV than gay-identified men. (Chris Green, a treatment advocate working with the Spiritia Foundation in Jakarta describes some of the challenges — as well as some progress — providing HIV services to the transgender population in Indonesia in a case study later in this article).

In addition, surveys use different methodologies to recruit participants — some of which gather more representative samples than others. Some studies send workers out in the community to places or venues known to be frequented by MSM — but this may only capture the most visible members of MSM. Another method to reach invisible and stigmatised population is ‘snowball sampling’ in which individual members of the NGOs or men known to them invite friends to answer the research questionnaire, who then invited other friends until they reached a desired sample-size. But this sampling method does not usually produce a representative sample of the entire population as it is essentially reliant on networks of friends and therefore all residents may come from a particular stratum of society. A variation of snowball sampling called respondent-driven sampling (RDS), uses a more structured approach that can be corrected for bias and is increasingly being used by studies.

Finally, Dr Cáceres noted there has been a lot of variation in behavioural questions, timeframes evaluated, etc, that makes it difficult to compare results from one survey to another directly.

## Men have sex with men in every country and culture – though the extent and public acknowledgement of it vary

Nevertheless, according to a global review Dr Cáceres conducted with UNAIDS published last year, the limited available data show that between 3% of men in Africa and almost 20% of men in Asia report having sex with other men.<sup>4</sup> The review included 14 studies from Africa, 62 from Asia, one from the Caribbean, five from Eastern Europe/Central Asia, 24 from Latin America and one from the MENA region. Whether the differences in reported same-sex activity reflects actual differences in behaviour or is due to a greater reluctance on the part of African men to be identified as an MSM is difficult to say.

MSM and transgender people often have multiple risk factors for HIV — such as injecting drug use, or sex work, which is especially common in contexts where they are rejected by the families and living on the streets. [A study in Mombasa, Kenya](#), estimated that at least 700 MSM were selling sex to men in and around the city.<sup>5</sup> Notably the sex was being sold to other Kenyans — not foreigners. This points to a much larger MSM population of MSM in Kenya overall, according to an accompanying editorial, as “most MSM do not sell sex.”<sup>6</sup>

Similarly, there may be around 40,000-50,000 male sex workers (malishias) and transgender sex workers (hijra) having sex with men in Pakistan, according to a recent [report on IRIN PlusNews](#). The article states that “although many MSWs are gay, poverty, lack of job opportunities and broken homes appear to be the driving force behind this activity.” As Pakistan is a conservative Islamic country, this population is ignored if not denied — but failing to address its needs risks putting Pakistan at risk of a larger HIV epidemic.

Shivananda Khan, founder of Naz Foundation International told HATIP “one issue that constantly crops up in South Asia is class and economic status, along with religious affiliation, particularly Islam, which has an enormous impact on risks and vulnerabilities.”

The majority of clients of male sex workers are often married men. Dr Cáceres review found that a substantial proportion of MSM are likely also report being married or having heterosexual sex.

### Frequent Heterosexual Behavior among MSM

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Region	Prevalence heterosexual sex among MSM ever Median (Range)	Prevalence heterosexual sex among MSM last year Median (Range)	Prevalence of marriage among MSM Median (Range)
Africa (not North)	64% (41-86%)	60% (50-69%)	12% (8-15%)
Asia	49% (25-73%)	54% (11-98%)	23% (3-42%)
Caribbean	78%	ND	41%
Eastern Europe and Central Asia	49% (44-53%)	ND	7%
Latin America	45% (25-64%)	19% (8-30%)	5%
Middle East and North Africa	ND	ND	16%
Total	55% (25-86%)	53% (8-98%)	23% (3-42%)

A [couple of other studies presented at CROI](#) also reported significant proportions of men who have sex with men have concurrent partnerships with both males and females. One, presented by Dr Chris Beyrer of the Center for Public Health and Human Rights at the Johns Hopkins School of Medicine in Baltimore, described findings from Malawi, Namibia and Botswana.<sup>8</sup> In terms of self-identity, two-thirds of men in Botswana identified as 'gay', 48% in Namibia and 40% in Malawi. In Malawi, 53% identified as 'bisexual' and 29% in the other two countries. Meanwhile, one in six (one in four in Malawi) was 'bisexually concurrent' with ongoing relationships with at least one partner of either sex.

Beyrer stressed that these men reported a high rate of condom use with their female partners and that he was encouraged by the high knowledge of HIV infection and prevention. But the sample may not really be representative of all MSM in those settings because the snowball sampling used in these particular surveys may have oversampled urban well-educated professionals who were unusually well-informed about HIV.

In contrast, in a study of largely rural or semi-urban and poor MSM in Tamil Nadu, India, 85% of MSM reported having also had sex with a woman, 60% defined themselves as bisexual and a third (34%) were married – but notably the married men were the most likely to be HIV infected and to have other sexually transmitted infections.<sup>9</sup> This group, according to the presenter Sunil Suhas Solomon, also of Johns Hopkins, could potentially spread HIV to their wives and needed further study in order to design appropriate prevention services.

## Evidence suggests there are MSM and transgender HIV epidemics virtually everywhere

In 2007, [a meta-analysis by Stefan Baral](#) also of Johns Hopkins pulled data from existing studies in countries in Latin America, Asia and in Africa on the risk of being HIV-positive as compared to men from the general population, in all of those regions.<sup>10</sup>

"Overall, the odds of having HIV infection are markedly higher among men who have sex with men than among the general population of adults of reproductive age across Asia, Africa, the Americas and the countries of the former Soviet Union," the investigators commented.

How much of an increased risk depended upon the setting and background prevalence of HIV. For instance, in Latin America, MSM had an odds ratio (OR) for HIV infection of 33.3 (95% CI 32.3–34.2), in Asia the OR was 18.7 (95% CI 17.7–19.7), while it was 3.8 (95% CI 3.3–4.3) for Africa. But in some individual countries, including Bolivia, Mexico and Egypt, MSM were more than 100 times more likely to be HIV-infected than the men in the general population. The overall HIV prevalence in MSM was around 16.1% in Latin America, 11.4% in Asia and 13.0% in Africa.

At a WHO technical consultation last September, Ed Saunders reviewed data from 2000 to 2008 on the HIV prevalence among MSM from Africa.<sup>11</sup>

### HIV prevalence among MSM cohorts in Africa

Country	Year	Prevalence	Country	Year	HIV prevalence

Egypt	2006 2008	1% 2.6%	Malawi	2008	21%
			Mauritania	2007	19%
Sudan	2005 2008	9.3% 7.8%	Senegal	2005 2007	22% 22%
Kenya Mombasa	2006	25%	Botswana	2008	20%
Kenya Nairobi	2007	37%	Cote D'Ivoire	2006	19%
Tanzania (Zanzibar)	2007	12.3%	Nigeria	2006 2007	13.4% 13.5%
Uganda	2008	15%	Namibia	2008	12%
Zambia	2006	33%	South Africa	2008	15%

Subsequent aggressive studies have documented a much higher rate of HIV among MSM in South Africa.

The data from one of the studies listed above comes from a vaccine preparedness study in Mombasa, Kenya.<sup>12</sup> Although the overall HIV prevalence for MSM at enrolment was 24.5% (95% CI, 19.7–30.7%), the HIV prevalence was 43.0% (95% confidence interval (CI), 34–52%) among men who had sex exclusively with other men and 12.3% (95% CI, 7–17%) for MSM who also had sex with women. Of MSM who reported anal intercourse in the last three months, 37% reported that all episodes had been without condoms. Over three-quarters of MSM (82%), reported at least one episode of unprotected anal intercourse with any partner in the last three months.

In Latin America, Dr Cáceres presented an analysis of data from the [UNAIDS Global Report 2008](#) showing that the relative burden of HIV is 10 to 15 times higher in MSM than in female sex workers. "However this pattern, according to UNAIDS, is not reflected in the prevention strategies," said Dr Cáceres.

In India, surveillance data suggest that the HIV prevalence among sex workers and the general population is going down. But Dr Cáceres cited WHO data from 2007 from 17 Indian states that paint a different picture among MSM. In only six states is the prevalence below 5%, while in four states, the prevalence is above 10%.

### HIV prevalence among MSM in the capital cities of Thailand, Cambodia, Vietnam and China<sup>13</sup>

	HIV prevalence among MSM	Adults in the general population
Thailand	24.6%	1.55%
Cambodia	7.8%	1.80%
Vietnam	2.8%	0.50%
China	3.8%	0.09%

Recently, there has been clear evidence showing that the risk of HIV infection is increasing in some countries.

For instance, [annual surveys carried out in China](#) show an increase in sexual risk taking and HIV transmission rates among MSM between 2004 and 2006.<sup>14</sup> In 2004 just 0.4% of the men were HIV-positive in 2004 but this shot up to 4.6% in 2005 and



5.8% in 2006. Hepatitis C infection rates also rose sharply from 0.4% in 2004 to 5.2% in 2006. These rises are being fuelled by a low rate of condom use and an increasingly number of sexual partners, according to the researchers.

Likewise, Thailand, which has been praised for its response to HIV among other populations, only recently began to gather sentinel data on HIV prevalence amongst men who have sex with men due to stigma and discrimination.<sup>15</sup> [When they did finally look](#), they found a 17% prevalence. However, subsequently, it has increased to 31%, [and a study presented at the World AIDS Conference last year](#) reported that 5% of men who have sex with men in Thailand acquire HIV each year.<sup>16</sup> Prevalence of STIs was also high: 44% of men had hepatitis B, 20% had genital herpes (HSV-2), 4% had syphilis, 9% had chlamydia, and 6% had gonorrhoea.

In all of these studies, the methods used to identify MSM were not perfect, and the cohorts sampled may not have been completely representative of the overall MSM and transgender populations in each country, and the reported prevalence cannot be considered to be exact. Nevertheless, these studies provide ample evidence of previously invisible subcultures in many settings where the legal framework and social prejudice have prevented the development of an open gay community — and made these individuals more vulnerable to HIV. And where epidemiological data are poor, data on access to prevention and care services is even worse.

## The waria of Indonesia

**A report from Chris Green, Jakarta**

**The HIV infection rate among 'waria' (transgenders) in Indonesia was estimated in 2006 to have reached at least 13% of a population estimated to be almost 30,000 - with a total clientele of almost 100,000. Surveys have shown infection rates over 25% in some waria populations here, with a 50% syphilis rate. Around 2% of the total number of HIV infections in Indonesia are thought to be among waria.**

**These figures are dwarfed by the gay population, but because prevalence among the gay population is one-tenth of that among waria, the totals of those thought to be HIV-infected is not far different.**

**The point I am making is that I feel we need to pay much more attention to the transgenders. They should not just be lumped together as part of 'MSM'. Both populations require different approaches, in care and support as much as in prevention.**

**In my experience, 'health-seeking behaviour' among waria is very low. Apart from discrimination which is common for all MSM, they attract ridicule. While their self-esteem is high at night when they are 'dolloed up', it drains away in daylight when they dress more normally. One group in Sidoarjo in East Java complained that their monthly one-hour public transport trip to the referral hospital in Surabaya to get their ARVs was purgatory, because of the continual mockery they received on the journey. While there are a number of gay doctors who frequently become the preferred providers for the gay community, there are few (if any) transgender doctors.**

**What's more, the gay community often prefer to keep the transgender community at arm's length, unwilling to be categorised as 'girly men.'**

**We find that if we offer help to waria, for example to transport them to a clinic, they tend to assume that we will take ongoing responsibility to support them. This results in an unwillingness among supporters to take any action.**

**There is of course little research on HIV among women; there is even less (if any) on HIV among transgenders. They clearly share many problems with men, but do they also share problems with women? (What is the CD4 cut-off for starting nevirapine among transgenders?) Concerns also arise over possible interactions between ARVs (and other drugs) with the hormones they often use to develop their breasts, and the compounds they inject into their breasts, lips and noses to enhance their shapes. (There is a worry that they may share needles to do so — not part of your normal harm reduction concern!)**

**Problems also arise if they need to be admitted to hospital. Almost invariably they are placed in a male ward. And if they must be accommodated in a home or hospice, again they are automatically classified as male. We can perhaps imagine how difficult it is for them, after a life-time of being a 'women', to have to revert to their biological gender when they are sick or old. On the other hand, to see a normally beautiful waria in a hospital bed with three-days growth of beard perhaps explains why accommodating them in a female ward could give rise to challenges.**

**As with other sex workers, we need to accommodate to their 'hours'. Clinics here tend to open from 8-12 a.m.; waria are almost certain to be asleep at that time.**

**Rapid solutions are needed; tests need to provide a result while you wait, because it is unlikely they will come back for them. Similarly, wherever possible treatment must be immediate and single dose, for example a single penicillin shot for syphilis, not a course which requires them to return regularly.**

**We need to provide clear guidance to the professions and to the transgender (and gay) community regarding anal pap-smears. Are these needed? How often? There are still many healthcare workers who laugh when we talk about pap-smears for men. And of course, better treatments are needed for anal warts.**

**Revealing one's HIV status is difficult for anyone; but it seems to be even more of a problem for waria. Waria often characterise themselves as catty gossips, and a waria recently diagnosed with HIV faces challenges receiving peer support, being scared to reveal her status to her waria friends. However, a number of peer support groups for HIV-infected waria have formed here, and have played a crucial role in providing support and advocating for improved services.**

**This problem of support is frequently exacerbated by lack of family support. Of course, this is also a challenge for gays, but waria have frequently been totally banished from their families, and have frequently run away and have lost contact with their families.**

**Despite all these challenges, progress has been made. I have mentioned the increasing number of peer support groups for HIV-infected waria. There are some waria who have been accepted and embraced by their families. There is at least one government hospital that allows waria to choose whether they would prefer treatment in a male or female ward. Although we have no separate statistics, an increasing number of waria are on ARV therapy, and manage to achieve high levels of adherence.**

**Shivananda Khan, founder of Naz Foundation International, told HATIP that “The same could be said of hijras in South Asia, along with feminine gendered men (who are not transgendered) such as kothis in India and Bangladesh, zenanas in Pakistan, ezaks in Afghanistan, metis in Nepal, apwint in Myanmar, and so on. It seems to me that the term MSM is also problematic in that it treats all males who have sex with males in a monolithic fashion without recognising cultural difference, indigenous identities, and so on.”**

## How to respond to the HIV epidemics among MSM in lower and middle-income countries

### Strengthen the evidence base

One of the first steps required to respond to the epidemic in MSM and transgender persons is to improve the quality of the data used to inform and develop policy.

“First we need to understand and reach MSM better,” said Dr Cáceres, “by improving epidemiological, service access and sociocultural information.”

For instance, MSM need to be included in regular HIV/AIDS surveillance; MSM-related questions should be included in population-based surveys, and the access of MSM and transgenders to prevention and care should be monitored.

“We should identify new ways of reaching hard-to-reach MSM — for instance isolated, not just gay identified, married men — with tailored/adequate programmes and prioritize special vulnerability contexts such as prisons, clients and sexual partners of male and transgender sex workers — and here new information technologies are becoming an excellent option [such as mobile phones and the internet]. But as this must be done, we have to remember that we should avoid exposing subjects to State violence. And we should remember that very clearly.”

### Prioritise human rights environment

The UNAIDS action framework emphasises that improving “the human rights situation for men who have sex with men and transgender people [is] the cornerstone to an effective response to HIV.”

Dr Cáceres concurred, saying that repression and criminalisation were absurd from a public health point of view, and should be eliminated and replaced by measures that protect human rights.

The UNAIDS framework goes into much more detail and lists a series of actions needed for a conducive legal, policy and social environment — including that “men who have sex with men and transgender people are appropriately addressed in national and local AIDS plans, that sufficient funding is budgeted for work, and that this work is planned and undertaken by suitably qualified and appropriate staff...” that these populations are empowered and engaged “in the planning, implementation and review of HIV-related responses, including the support of nongovernmental and community-based organizations, including organizations of people living with HIV” as well as training and sensitizing health-care providers to avoid discriminating against, and ensure the provision of appropriate HIV-related services for, men who have sex with men and transgender people,” and so on.

An example of the training/sensitization is provided by the Get Hip initiative in Ghana, funded by USAID, described at the HIV Implementer’s Meeting in Kigali by Dr Lydia Clemmons. HIP is the High Impact Package of tools and interventions specifically targeting most at risk populations (MARPs) including female sex workers and MSM.

“We developed special tools and interventions specifically for MARPs. An example is a health worker who has never done a case history of MSM, needs some tools and some guidance. They need training, they need stigma reduction and they also need just a simple list of questions i.e. What do you even ask someone who’s actually MSM when you’ve never even encountered that population before?” said Dr Clemmons.

The programme was developed after considerable dialogue with the target communities (with over 2 220 MARPs). She noted that the health services were the last place that MARPs in Ghana wanted to go to, because of the fear of stigma. But they hired peer educators, and also had MSM and other MARPs work with the health facility staff as trainers. Dialogue was ongoing, and the community provided feedback on the quality of services delivered.

“We did identify a number of ‘trouble-makers’ at the facility level. These were nurses, especially who had extremely negative attitudes towards people who were HIV-positive or towards MSM or sex workers. Names were named. Like this person, this is what she does to us. So those people who were identified were either re-trained or they were transferred out. Again, this type of action was immediate and it bought feedback to the communities,” she said

### Ensure access to effective prevention, treatment and comprehensive care

The UNAIDS framework recommends that “All interventions should be evidence-informed, developed with, and protect, the rights of, men who have sex with men and transgender people and should include safe access to:

- Information and education about HIV and other sexually transmitted infections, and support for safer sex and safer drug use, through appropriate services (including peer-led, managed and provided services);
- Condoms and water-based lubricants (repeatedly in study after study in Africa, MSM complain of having little access to appropriate lubricants which don’t break condoms);
- Confidential, voluntary HIV counselling and testing;
- Detection and management of sexually transmitted infections through the provision of clinical services (by staff members trained to deal with sexually transmitted infections as they affect men who have sex with men and transgender people);

- Referral systems for legal, welfare and health services, and access to appropriate services;
- Safer drug-use commodities and services;
- Appropriate antiretroviral and related treatments, where necessary, together with HIV care and support;
- Prevention and treatment of viral hepatitis;
- Referrals between prevention, care and treatment services; and
- Services that address the HIV-related risks and needs of the female sexual partners of men who have sex with men and transgender people.

Dr Cáceres suggested that novel prevention technologies must be explored in MSM through coherent and reasonably-sized studies. He also stressed the need to provide comprehensive care that goes beyond directly treating HIV/AIDS to address issues such as sexual health care including sexual dysfunction, mental health including violence, substance abuse, and so-called sex addiction. More progressive and better-resourced countries such as Brazil are even assisting transgenders seeking gender reassignment.

It is extremely difficult to imagine low-income countries in Africa or MENA going for something like that. It would seem sensible to set the sights a bit lower and start out by trying to change hearts and minds for a modicum of tolerance in these countries. As the authors of the World AIDS Conference 2008 Impact Report wrote "Perhaps additional advocacy efforts targeting political leaders and government officials are required to turn the language former Botswana President Festus Mogae used in his Opening Session speech regarding "people who engage in unusual sexual practices" into an explicit acknowledgment of MSM in Africa – and other regions – and their importance in the HIV surveillance systems that have not served them well to date."

Indeed, the fact that former President Mogae is one of the most forward-thinking leaders in Africa (but from a country where homosexuality is criminalised), illustrates what an uphill battle it will be to get those who know less about HIV/AIDS to acknowledge the need to respond to this stigmatised segment of society.

## Developments in advocacy

Dr Cáceres believes, however, that "criminalization is becoming politically unsustainable in Africa. But even in countries with restrictive legal systems, MSM will work with public health authorities to improve their situation and society at large, if their confidentiality and privacy are protected, they are treated in a non-judgmental way and with respect and their legal and social situation is addressed simultaneously."

The last few years have seen numerous developments in advocacy to address this issue. As this article has demonstrated, there has been a dramatic increase in information describing these previously invisible populations. The issue was highlighted at the World AIDS Conference, where there was the first-ever March against Homophobia at a World AIDS Conference, and subsequently at ICASA. A forum devoted to the issue was held before the South African AIDS Conference (an executive summary and the pdfs from the meeting can be found [here](#).)

Increasingly, countries are beginning to politically recognise and include MSM in national HIV surveillance and national plans for HIV. MSM friendly clinics for HIV VCT and STI services are being initiated in several countries.

Communities of MSM in a few countries of Africa are now more actively demanding that their health care and HIV prevention needs

be addressed. There is a growing chorus of gay bloggers in Africa ([for links to some of the blogs see a useful overview here](#)).

The legal framework has changed in several countries, including throughout the Latin American region (though not the Caribbean). And on 18 December 2008, a joint statement was read in the UN General Assembly urging all nations to "promote and protect human rights of all persons, regardless of sexual orientation and gender identity," with 66 signatory nations. Of course, that means that over 120 countries did not support the statement— including the United States.

The United States has been more than somewhat schizophrenic on the issue. On the one hand, USAID/PEPFAR has supported some very progressive and inclusive programmes such as Get HIP in Ghana and the Health4Men services in Cape Town (see accompanying article). But at the same time, PEPFAR-funding has strengthened the hand of some most intolerant faith-based organisations in sub-Saharan Africa. It is unclear where President Barack Obama really stands on the issue, despite paying lip service to equality on the campaign trail.

Nevertheless, we would hope that the US government sends a very clear signal, at the upcoming HIV Implementer's Meeting in Windhoek, that there should be no events like those at last year's Implementers' Meeting in Kampala, Uganda, when three gay and lesbian rights activists were arrested, or what happened later in the year in Senegal, where several peer educators working with MSM were arrested and imprisoned after participating in the ICASA meeting.

Negative press and political pressure ultimately resulted in charges being dropped in both of these cases — but it should never have happened in the first place, and these cases illustrate the very real risks that gay activists take to organise any sort of community response to HIV in countries where homosexuality is still criminalised.

The United Nations Development Programme (UNDP) will lead the interagency work on MSM for the UN, with the founding Executive Director of the International HIV/AIDS Alliance, Jeff O'Malley, chosen to direct the effort.

A growing number of funders, including the Elton John AIDS Foundation, the Bill and Melinda Gates Foundation and the Foundation for AIDS Research (AmFAR) have been supporting a variety of projects working with MSM and transgender communities. In particular the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has announced a new emphasis on gender, including attention to sexual minorities, in its funding guidelines for Round 8 onwards, and is taking steps to make certain that its country-led priority setting process better addresses the needs of sexual minorities.

## Resources

### The Global Forum on MSM & HIV

<http://www.msmandhiv.org>

### Amfar's MSM Initiative

<http://www.amfar.org/msm/>

### Men who have sex with men:

[Key operational guidelines of the UNAIDS Programme](#)

[UNAIDS article](#) describing HIV epidemic in countries of the former Soviet Union

[WHO Rapid Assessment and Response Guide](#): adaptation guide on HIV and men who have sex with men



### The International HIV/AIDS Alliance's **Frontiers Prevention Project**

At AIDS 2008, the Frontiers Prevention Project reported on a model programme and successful HIV prevention campaign for sex workers and men who have sex with men in Andhra Pradesh, India.

### Naz Foundation International

Provides technical assistance and support to MSM groups and organisations in Asia

<http://www.nfi.net/index.asp>

### Africagay

A coalition of 18 organisations in 10 countries of Francophone Africa: du Burkina-Faso, du Burundi, du Cameroun, du Mali, du Maroc, du Niger, de la Cote d'Ivoire, de la République Démocratique du Congo, du Sénégal, de la Tunisie et de la France.

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# HIV prevalence among South African MSM twice as high as general population

By Theo Smart

### With additional reporting by Lance Sherriff

The HIV prevalence among men who have sex with men (MSM) in South Africa is much higher than among men in the general population according to three separate epidemiological surveys presented at the South African AIDS Conference earlier this month. 43.6% of the participant's in one study in Johannesburg and Durban (eThekweni) were HIV-positive; in another, the prevalence among men between the ages of 20 to 24 who identified themselves as gay was 49%. Most of these surveys' participants were black – and the one study that could look somewhat at race (in Cape Town) found a significantly higher prevalence of HIV among participants from traditionally black townships than among those from coloured townships.

But even though the HIV prevalence varied somewhat from study to study (depending upon the sampling method, race of the participants and study site), they each found a heavy burden of HIV among young MSM – especially those who are gay-identified – to which the public health system has not been responding appropriately.

"There are actually parallel HIV epidemics in South Africa," said Professor Laetitia Rispel of Wits University, who was one of the principal investigators of the Johannesburg/eThekweni's Men's Study (JEMs). "There's the generalised heterosexual epidemic but there's also a hidden, perhaps forgotten epidemic, among MSM, who to a large extent have fallen off the agenda over the last 15 years."

## Background

"Whilst HIV infection amongst MSM was the focus in the early phases of the epidemic in South Africa, there is currently very little known about the epidemic amongst MSM in the country," said the National Strategic Plan on HIV and AIDS 2007-2001.

In South Africa in the early 1990s, just like most of the industrialised world, HIV was associated with the visible gay male population, who, it was widely thought, were mostly white. The country was in denial about at least two things: 1) that HIV wasn't a problem in the general population, and 2) that men of all races were having sex with men. The reality of the epidemic among the general population proved too much to disguise, but as in much of the rest of Africa, MSM continue to be a marginalised, hard to reach and under studied population.

However, in most of the developing world, the studies that have been conducted indicate that MSM are at a higher risk of HIV infection than the general population. According to [a review in PLoS Medicine](#), the prevalence among MSM is about ninefold higher than the general population in medium-high HIV prevalence countries, though only a couple of sub-Saharan African countries were included.<sup>1</sup> In the last couple of years, this understanding has become more nuanced as data have become available for many other African countries (see accompanying article).

In South Africa, by 2007, the NSP finally called for more information on HIV among MSM and also for programmes to reach



the most at risk populations, including MSM. There were so little reliable data that the country was unable to report on indicators for MSM for the UN General Assembly progress report on universal access to HIV treatment and prevention submitted to the UN early 2008. Since that time, several studies have been launched.

## The JEMS study

The JEMS study was a collaborative effort between the Wits University in Johannesburg, the Human Sciences Research Council (HSRC) and the Medical Research Council.<sup>2</sup> Before the survey, the researchers conducted extensive background research with a literature review, focus group discussions and interviews with key 'informants' from the LGBT community in Johannesburg, Durban, Cape Town, Pretoria and Pietermaritzburg. The survey of HIV prevalence and behaviour was focused on Johannesburg and Durban, because other groups were conducting similar surveys in Cape Town and Pretoria.

The survey recruited men using respondent-driven sampling (RDS) – a form of chain sampling which has been used extensively in other studies to recruit members of “hard to reach” populations. Eligibility requirements for the study included being male, aged 18 years or more, and having had sex with at least one other male in the past 12 months, and living, working or socializing in Johannesburg or Durban. With RDS, the initial participants are called “seeds” and these were deliberately chosen to be diverse in terms of age, race, socio-economic status, and to have large social networks. Each participant was asked to recruit up to three more participants. They were reimbursed for their participation, with a R40 (£3) cash and R40 voucher and were also reimbursed R40 for each additional participant they recruited (max. R120) (these amounts were thought to be enough of an incentive without being coercive).

After answering the survey questionnaire, 95% of the subjects provided dried blood spot samples that were linked to his answers and sent to the laboratory anonymously. Participants were also offered free VCT using a rapid HIV test with same-day results as an additional optional service to participants.

## JEMS Results

The study accrued 285 participants in all (204 JHB and 81 Durban). 88% were black African (in a separate poster presentation, the researchers noted that despite their efforts and use of RDS, the population wasn't as diverse as they would have liked, with very few white men for instance).<sup>3</sup>

Most of the participants were young – ages ranged from 18 to 61 years old – but two-thirds were under 25 years old (mean age 24.5 years; median age 22 years). 78% self-identified as homosexual or gay; 19% bisexual; 2% heterosexual or straight and 2% as (which included transgender individuals. 54% had greater than or equal to a grade 12 education.

In the 266 who tested, the unadjusted HIV prevalence was 43.6% among the participants. However, the researchers made some adjustments for the RDS-method to take into account that people tend to recruit people similar to themselves (and with similar HIV status), and came up with a prevalence of 38.3% that should be more representative for the MSM in this setting.

This prevalence was “at least twice as high as what one would expect from the general population,” said Dr Carol Metcalf, one of JEM's investigators. In the national household survey conducted in 2005, the HIV prevalence among men aged 30 to 49 was 11.7%;

and the ASSA (Actuarial Society of South Africa) estimate for 2008 of men aged 30 to 49 was 15.9%.<sup>4</sup>

In general, high-risk sexual behaviour was more common among people who were HIV-positive than those who were HIV-negative. In the previous 12 months, almost one in two participants – around 46% – reported having unprotected anal intercourse within the past year. The HIV-positive participants were more than twice as likely to have receptive unprotected anal intercourse within the past year. HIV-negative men reported an average of five partners in the past year while HIV-positive men reported an average of 7.5.

The participants reported that condoms were often unavailable and condom accidents were common. 55% of the respondents reported that they didn't have a condom available when they needed one. 42% reported at least one instance of condom slippage and 58% reported an instance of condom breakage in the past year. In addition, many participants reported using lubricants that actually reduced the protective effect of condoms, such as Vaseline or lotion (which are more readily available in South Africa and much less expensive than the water-based lubricants).

Seventy three per cent of the participants reported that they had sex under the influence of alcohol in the past year (and there was no difference between HIV-negative or HIV-positive participants). Another interesting finding was that more than a third of participants reported having experienced sexual coercion – which was significantly associated with being HIV-positive.<sup>5</sup>

Of note, the men in the sample generally perceived their risk to be low. Prof Rispel said that one reason for this, which came out of focus group discussions, was that most thought that heterosexuals in South Africa were at greater risk of getting HIV than MSM. 57% of the participants reported that they knew their HIV status, but only two-thirds of those who knew their status had disclosed it to a sexual partner within the past year.

Dr Metcalf noted that the survey also included some questions about sex with women. “What is striking from these findings is that the vast majority of HIV-positive men in our study (reported) that they have never had sex with a women,” she said. Only 36 reported ever having had sex with women, and only one out of five of the HIV-positive participants. In the last year very few had had sex with women, and even fewer had unprotected or regular sex. Since there was such a low degree of sexual interaction with women, the JEMS team concluded that the epidemic of HIV among MSM probably does not overlap much with the larger HIV epidemic in South Africa; it is rather running in parallel.

However, Dr Metcalf stressed that this cohort may not be absolutely representative of MSM in South Africa:

“Our participants were predominantly young, gay, black Africans who do not think they were ‘representative of MSM in general or even MSM in the two cities. They don't actually know what a representative sample would look like,” she said.

But it isn't clear that the other samples described at the South African AIDS conference were entirely representative either.

## A survey in Soweto

One was another RDS survey, conducted in South Africa's largest township, Soweto, which comprises 85% of the Metro Johannesburg population. This survey seemed to draw in a cohort with somewhat different characteristics, with a much higher proportion of men who categorise themselves as bisexual or straight.

According to Sibongile Dladla, of the Perinatal HIV Research Unit (PHRU) in Johannesburg, MSM in Soweto are “stigmatised and hidden” and unlike other settings in the country, there were no data

from LGBT community-based organisations providing HIV services to this population. So researchers from PHRU set up the Soweto Men's Study to better characterise the MSM population in the township, estimate the HIV prevalence; and determine the social behavioural predictors of HIV infection.<sup>6</sup>

The study included men over 18 years of age who had had oral or anal sex with another man in the last six months and who lived, worked or socialized in Soweto. Again, "seed" participants were used to recruit their peers over a period of 30 weeks, and were compensated with coupons (R30 or US \$5 gift cards, limited to 3 to 5 per participant). Recruitment continued until the target sample size was achieved. Participants were administered a questionnaire, and then offered VCT.

### Soweto Men's Study results

378 men were recruited, aged between 18 and 58 years old (median=23). 99.9% were black South African residents of Soweto (40% Zulu, 17% Sotho, 12% Tswana). Ms Dladla stressed that unemployment is high in Soweto, with 77.5% of the participants earning less than R500 per month. Of note, 33.6% of those in the cohort were circumcised.

About 81% agreed to be HIV tested for the survey though many declined their results (including 29% of new HIV-positive diagnoses). About one out of five of those who tested positive already knew their status. Fifteen per cent had never tested prior to the study; 59% had not tested within the last year.

Twenty per cent of those who consented to VCT, tested HIV positive, but an adjustment for the RDS method suggested the representative prevalence for this population would only be 10.9% (95% Confidence Interval (CI) 6.5-14.6). However, as noted earlier, this sample seemed to have markedly different sexual identities and behaviour from the JEMS cohort.

Only 34.1% identified themselves as gay. 30.4% claimed to be bisexual, and another 31.7% said they were straight. 51.2% claimed to have a regular female partner, with 48.7% reporting at least one female partner among their last five partners. 37.8% reported having unprotected sex with women. Of note, adjustments for the RDS pushed the likelihood of heterosexual behaviour higher. In fact, one has to question whether a significant proportion of the sample may have actually been completely straight.

Seventy three per cent reported having a regular male partner. And yet, in marked contrast to the previous cohort, only 28.6% reported unprotected insertive anal intercourse in the last 6 months, and only 17.5% had unprotected receptive anal intercourse in the previous 6 months.

HIV prevalence among the gay-identified individuals was markedly higher: 47% of those tested overall, 34.5% after adjustment, while the prevalence among 'bisexual or straight' was 13.6%, or 9.4 after adjustment.<sup>7</sup>

An analysis by age and sexual identity was also telling. In South Africa, 3.3% of young men aged 15-19, and 6% of men aged 20-24 are HIV-positive. This compares to 9.4% and 23.9% of women in the same age groups. In this study, the rate for all the participants overall was 8.5% and 38.5% for the same age groups; but among the gay-identified participants, 9.8%, and 49% respectively were HIV-infected.

"The epidemic appears to be spreading rapidly among young, gay-identified MSM," said Ms Dladla.

### Soweto MSM risk factors for HIV

Variable	OR (95% CI)
Age > 25	3.8 (3.2 - 4.6)
Gay ID	2.3 (1.8 - 3.0)
Income < R500	1.4 (1.2 - 1.7)
3 to 5 partners in the past 6 months	1.9 (1.4 - 2.6)
Buy drugs / alcohol for male partner	3.9 (3.2 - 4.7)
Unprotected RAI	4.4 (3.5 - 5.7)
Regular female partner	0.2 (0.2 - 0.3)
Circumcised	0.2 (0.1 - 0.2)

### A comparison of townships in Cape Town

However, a study in Cape Town, which did not use RDS, also found a higher rate of bisexuality and female partners among black MSM. But the black MSM in this study were three times more likely to be HIV-positive as coloured MSM, who were more likely to be exclusively gay-identified.

"To date, there has been no assessment of whether sexual risk behaviours and HIV prevalence among men who have sex with men (MSM) vary between historically distinct black and coloured townships in Cape Town," said Earl Ryan Burrell of the Desmond Tutu HIV Foundation (DTHF).

So in partnership with Johns Hopkins University, Burrell and colleagues at DTHF conducted an anonymous, venue-based HIV-risk behaviour and prevalence assessment of 200 self-identified MSM from townships (some traditionally black, others traditionally coloured) in Cape Town, South Africa. Over a period of 27 days, health workers administered a demographics and sexual risk behaviour questionnaire and an oral HIV test at twelve venues known to be frequented by MSM.<sup>8</sup>

Researchers soon noticed a difference in HIV prevalence associated with data collected at separate venues — which depended on whether they were in traditionally black versus coloured townships (which the researchers used as a proxy for race).

### Cape Town results

In Cape Town 25.5% (51/200) of the cohort were HIV positive, with a significantly higher prevalence of 37.3% (38/102) among black MSM compared to 12.5% (11/88) among the coloured MSM ( $p=0.000$ ). (Ten individuals were mixed race and excluded from this analysis).<sup>9</sup>

With such a profound difference in HIV prevalence between the two populations, the researchers looked at whether any demographic or behavioural characteristics would explain differences in risk.

There were no significant differences between MSM in traditionally black versus coloured townships in age (mean 25.9 years, range 18-49) or high school education, with 10.5% (20/190) having had less than a matric education. Only 1.4% of the sample subjects identified themselves as either straight or heterosexual. The mean number of male sexual partners in the previous six months was 4.2; about 22.1% (32/145) of the sample reported inconsistent condom use with casual partners; 25.3% (48/190) reported ever receiving treatment for an sexually transmitted infection; while 19.5% reported engaging in transactional sex.

There were some significant differences however, such as a higher rate of unemployment in the black township. There were also differences in sexual identity. Transgender MSM were much more common in the coloured townships. About 25.0% of black MSM identified as bisexual compared to 12.5% of coloured MSM ( $p=0.035$ ), and black MSM had a mean of 0.8 female partners in the previous 6 months compared to 0.1 female partners among coloured MSM ( $p=0.0016$ ). As far as sexual behaviour went, coloured MSM were less likely to use condoms with their main male partner than black MSM; black MSM were less likely to have tested for HIV in the last six months, and more likely to report using petroleum-based lubricants with condoms.

However, only a number of variables were significant predictors of HIV infection in univariate analysis: being sampled in a black township ( $p=0.000$ ), having less than a matric education ( $p=0.009$ ), reporting current unemployment ( $p=0.007$ ), and not having had an HIV test in the previous 6 months ( $p=0.002$ ) (each of these also remained significant in the multivariate analysis). But *no* sexual risk criteria were significantly associated with HIV positivity in this sample.

Nevertheless, Burrell suggested that “the variation in HIV prevalence here may be driven by the community-specific background HIV infection.” In other words, it is theoretically possible that HIV risk in the background general population could provide a baseline prevalence, which is then amplified within the respective MSM population.

Burrell noted that it would take further data looking at HIV clades, and utilizing phylogenetic tree and molecular clock analysis to determine if HIV epidemics among MSM in Cape Town are parallel or linked to a more generalized epidemic. Indeed, years ago, data suggested that most of the HIV among MSM in this population was HIV-1B, the same as in MSM in Western countries, while HIV-1C is the dominant clade among the general population in South Africa.<sup>10</sup> Thus, simply finding much HIV-1C among the MSM, particularly the gay identified MSM, would be telling.

However, there may be behavioural or other variables that were not assessed in this survey – such as the lack of prevention messages being targeted to the black MSM population in their own languages. Several of the researchers reported that prevention messages are not effectively targeting this population

## Prevention, testing and treatment services for MSM

“It is clear, the current HIV response in South Africa does not meet the needs of MSM,” said Dr Metcalf. Her colleague Professor Rispel described some of the challenges MSM have in accessing services from the public sector.

“Although the majority of survey participants, 57%, had used public health services in the past year (most had little choice because they had no private medical aid), only 7% of individuals said that they would prefer to receive HIV prevention services from a government health service rather than from other service providers,” she said.

From the interviews and focus group discussions, the JEMS researchers found that the only services that exist for MSM are usually provided by non-governmental organizations (usually from the LGBT community) – and with limited capacity or resources these services only reach a very limited number of men.

“One of the issues that came through repeatedly – and it also confirms the findings of other studies – is the unresponsiveness generally of health services to MSM. Health workers often display

negative and judgmental attitudes and they tailor clinical management almost exclusively towards heterosexuals. This made men very reluctant to use healthcare services, particularly public health services,” said Prof Rispel. “And due to persistent stigmatization of homosexuality, some MSM fear to disclose their sexual practices and sexual identity to health workers.”

This translates in a reluctance to test as well.

One recent and notable exception is the Health4Men service from PHRU, supported by funding from PEPFAR/USAID, the Elton John AIDS Foundation and others. The first Health4Men service opened in the heart of Cape Town’s “gay village” earlier this year. It launched a progressive prevention campaign targeting MSM (<http://www.playnice.me/>) and then opened a clinic providing MSM-friendly HIV treatment services at Woodstock Hospital in partnership with the Western Cape Department of Health. PHRU plans to expand the Health4Men service to Soweto and Durban, and their work was acknowledged by South Africa’s Deputy-President of South Africa, who described it as a model for future services in her keynote address at the opening of the South African AIDS Conference.

## Moving forward

“The responsiveness of the health system - particularly the public health system - must be improved,” said Prof Rispel. “Firstly through educating healthcare professionals to care for MSM and other sexual minorities in a sensitive and non-judgmental manner. I should say that South Africa is of course the only African country where discrimination on the basis of sexual orientation is outlawed in the highest law of the country so there are already legal provisions for these recommendations that we are making. But certainly, some of the aspects in having a more responsive health system, is educating health professionals, revising existing clinical guidelines to address the needs of MSM, looking at outreach services and also providing support and funding to organizations that are already providing services to MSM.”

In addition to expanding efforts to “eliminate the barriers to VCT and treatment for MSM,” PHRU’s Dladla believes there is a need to “strengthen community-building among MSM.” Likewise, Dr Metcalf said “We need to address structural factors and ensure upholding of human rights of MSM in line with our constitution and also address stigma and discrimination.”

Without such efforts, much of the MSM community is likely to remain “hidden” and under-served.

Finally, the JEMS team said that it is critical that the government must take responsibility for ongoing national surveillance of the HIV epidemic among MSM. “It must be coordinated by government and obviously government should draw on the resources of researchers,” said Prof Rispel.

Dr Metcalf added that this surveillance also needs to “assess the extent of the HIV epidemic among larger, more diverse and ‘representative’ sample.”

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