

HIV prevention needs for men who have sex with men in Swaziland

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Men who have sex with men (MSM) have a high HIV burden and also often face multiple other challenges accessing HIV services, including legal and social issues. Although Swaziland recently started responding with interventions for MSM, significant gaps still exist both in information and programming. This study aimed to explore the HIV prevention needs of MSM in Swaziland, including factors elevating their risks and vulnerabilities to HIV infection; to find out what HIV prevention strategies exist; and to determine how best to meet the prevention needs of MSM. A total of 50 men who reported anal sex with other men in the past 12 months were recruited through simple respondent driven sampling. They completed either a structured quantitative survey ($n = 35$) or participated in a semi-structured qualitative interview ($n = 15$). Both quantitative and qualitative findings indicated perceived and experienced stigma among MSM. This predominantly manifested as internalised stigma, which may lead to alcohol abuse and sexual risky behaviours. At least 83% (29/35) of the quantitative sample had been labelled with derogatory terms because of their sexual orientation, while 66% (23/35) had experienced being avoided. There was limited knowledge of risk practices: When asked, 54% (19/35) of quantitative respondents reported that vaginal and anal sex carry an equal risk of HIV infection. Participants also had little knowledge on new HIV prevention methods such as pre-exposure prophylaxis (PrEP) and rectal microbicides. MSM needs included safe spaces in form of drop-in centres and non-hostile HIV services. Although Swaziland recently started interventions for key populations, including MSM, there is still a general lack on information to inform managers and implementers on the HIV prevention needs of MSM in Swaziland. Such information is crucial for designers of official and HIV programmes. Research is needed to increase knowledge on the HIV prevention needs for key populations, including MSM.

Keywords: fear, key populations, risks, stigma, vulnerabilities

Introduction

Key populations, including men who have sex with men (MSM) remain disproportionately affected by HIV, despite impressive recent global strides in halting and slowing the epidemic (Baral, Grosso, Holland, & Papworth, 2014). In major urban areas HIV prevalence among MSM is on average 13 times greater than in the general population (WHO, 2014). MSM and other key populations have a high HIV burden and often face multiple challenges when accessing HIV services, including legal and social issues related to their behaviour which increase their vulnerability to HIV (LINKAGES, 2017).

Within the generalised HIV epidemics of sub-Saharan Africa, some have suggested that key populations are less relevant because HIV transmission is primarily sustained in the general population with average HIV acquisition and transmission risks. However, that may be based on the fact key populations are often excluded from surveillance systems (Baral & Mafuya, 2012). Health data, including HIV prevalence data, are less robust for key populations than for general populations due to several complexities, including criminalisation, stigma, and discrimination, and investments in most countries have focused on the general population (WHO, 2014).

In other parts of the world, the HIV epidemics are generally

concentrated in the same populations that are excluded from the primary HIV surveillance systems in sub-Saharan Africa. While the importance of key populations was recognised in the early phases of the HIV epidemic in many nations in this region, their importance was devalued when the HIV epidemics became widespread in the general population (Baral & Mafuya, 2012). However, the prevalence of risk factors did not decrease with the decreased attention to their needs. In many settings, HIV incidence in the general population has stabilised or fallen — for example, the HIV incidence in Swaziland for adults aged 15–49 declined from 2.5% in 2011 to 1.7% in 2016 (UNAIDS, 2017). Despite these achievements, no data exist for key populations, and, globally, key populations continue to experience significant HIV burden, influencing the dynamics of HIV epidemics (WHO, 2014).

Even HIV prevention efforts routinely neglect MSM and other key populations. Recently, the World Health Organization (WHO) asserted countries should prioritise their HIV response to focus on the populations that experience the highest burden of HIV and are currently underserved (WHO, 2014). In 2009 the Government of the Kingdom of Swaziland and the National Emergency Response Council on HIV and AIDS (NERCHA) identified men who have MSM and female sex workers, people who inject drugs and prisoners as key populations in the National

Multi-Sectoral Strategic Framework for HIV and AIDS of 2009–2014 (NERCHA, 2009). This was also included in the extended National Multi-sectoral Strategic Framework for HIV and AIDS of 2014–2018 (NERCHA, 2014). Through the Swaziland National AIDS Programme, the government has started focussing on key populations, including MSM in line with international HIV agenda, with the first bio-behavioural surveillance survey for MSM and female sex workers conducted in 2011. To date, the Ministry of Health with support from partners has conducted the first size estimation survey for MSM and female sex workers.

Although the ground has been set with some studies on key populations, mostly via one 2011 study which focused on MSM and female sex workers (NERCHA, 2014), more research is needed to elucidate the needs of key populations to inform potential interventions or policies. These data limitations are noted in Swaziland's current national HIV/AIDS strategy (NERCHA, 2014); the earlier strategy also identified significant gaps in the provision of services among key populations (NERCHA, 2009). Although MSM face legal and social challenges when accessing legal and health services, as noted in prior studies in Swaziland, there is need to expand information on the HIV prevention needs of MSM in Swaziland (Kennedy et al., 2013).

The aim of the study was to determine the HIV prevention needs of MSM in Swaziland to provide information that can inform HIV and AIDS policies and programmes on specific HIV prevention strategies tailored to MSM. There is general lack of information on MSM and HIV; this study was the first to investigate the specific HIV prevention needs of MSM in Swaziland. The study was also motivated by the fact that national health officials, health workers, managers of HIV and AIDS programmes and non-governmental organisations can benefit from knowledge on the HIV prevention needs of MSM. Such knowledge may be useful in scaling up HIV prevention programmes.

Methods

Sampling and recruitment

A convenience snowball sampling, based on a modified respondent driven sampling approach was used to recruit study participants from January to March 2013, on the grounds that this was an appropriate and feasible way to obtain an adequate number of respondents for the study. To be eligible for the study, participants had to report being assigned the male sex at birth, being aged 18 years or older, having had anal sex with another man in the past 12 months, speak siSwati or English, and be capable of providing written informed consent.

The researcher approached four MSM in Manzini known to him and who were "gatekeepers", who were representatives of different MSM networks in the town. These individuals were asked to recruit three MSM individuals to the study. The "seeds" who had participated first then produced the first wave of individuals by inviting their peers, who in turn invited another three MSM potential participants that made the second wave. The second wave then produced the third wave, and so on. The intention was to secure a sample of 50 MSM for a mixed method study design that was used. Thirty-five MSM consented to participate in the quantitative

survey and 15 participated in the qualitative method for a total sample of 50. As this was an exploratory study, the sample size of the quantitative part of the study was based on convenience in accessing the eligible MSM in Manzini through the snowball sampling. The sample was guided by the networks that could be reached through the snowball sampling and those participants that consented to participate.

Six managers of HIV prevention programmes working on key populations were also engaged as key informants. Key informants were included to provide information about HIV prevention programmes currently available for MSM, and prevention needs.

Data collection techniques

Quantitative data were collected using a structured questionnaire with closed-ended questions. Qualitative data were collected guided by semi-structured interviews. The qualitative interviews were audio-recorded and later transcribed. Both the quantitative and qualitative data collection tools were in paper format and were administered by the researcher.

Study procedure and survey instrument

For both qualitative and quantitative interviews, each participant completed an in-person interview with the researcher in a private setting where the participant was comfortable. The interview lasted approximately one hour. The quantitative survey instrument contained modules on socio-demographics; sexual orientation; risks and vulnerabilities to HIV; sexual behaviours (HIV prevention practices); and information, education and communication. Questions asked on the qualitative portion of the study were around issues that put MSM at risk for and vulnerable to HIV infection, identifying HIV services provided to MSM and their knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland.

Data analysis

Quantitative survey data were analysed using basic descriptive statistics to describe central tendency and variability using the Statistical Package for the Social Sciences (SPSS®) software. The qualitative data were analysed by transcribing data from voice recorders, coding the data and identifying themes. The data were then grouped according to the identified themes. All the data collection and analysis was conducted by the author, who has experience working with and conducting research among key populations, including MSM.

Ethical review

Ethical approval for the study was granted by the Scientific and Ethics Committee of Swaziland and the Human Research (Humanities) Ethics Committee at the University of Stellenbosch. Informed written consent was obtained from each participant. Consent to participate in the study was sought from participants through signed consent forms, which were signed by the researcher on behalf of consenting participants. This was to ensure signatures of participants were not identifiers to protect their identity. There were no identifiers used. Data were only identified by unique serial numbers and alphabets. All information generated during

data collection was safeguarded to ensure confidentiality by being locked in a safe place and used only for this study.

Results

Survey

Thirty-five men were recruited and interviewed as part of the quantitative study. Overall, the sample was young: 28 (80%) were under 30 years old. Most of the respondents ($n = 30$) identified themselves as gay, whereas the rest identified themselves as bisexual. Of the 35 respondents, 77% self-identified as men, while 23% ($n = 8$) identified as “women” (identifying with the female gender). Most of the participants 62% (22, $n = 35$) reported having never been married, either to a man or a woman, and were living without sexual partners. Most of the sample, 88% ($n = 31$) did not have any children while 12% ($N = 4$) had either 2 children or more. Respondents were asked questions related to risks and vulnerabilities, and access and uptake of HIV prevention services, and their knowledge of some HIV prevention strategies. Table 1 summarises the findings.

Qualitative findings

The qualitative interview guide included the following sections: understanding risks and vulnerabilities; information on available and suggested HIV prevention strategies for MSM; and available and suggested information, educational and communication strategies. Most of the interview participants for qualitative research ($n = 13$) were below age 30. All participants reported having had sex with another man in the past 12 months. Most participants ($n = 12$) identified themselves as gay while the

remaining 2 identified as bisexual. Most interviews lasted approximately 45–60 minutes.

Risks for and vulnerabilities to HIV infection among MSM: personal factors

Participants stated that there were personal factors that put MSM at risk of HIV infection. These factors were: self-stigma; multiple concurrent partnerships, and short-term relationships; decision on condom use; and misconception about anal sex.

Fear of being stigmatised was common among the participants. They stated that such self-stigma emanates from the societal homophobic stigma. Participants further stated that most MSM end up abusing alcohol to gain confidence which in turn leads to risky unprotected sex. One of the respondents stated on stigma:

It is common to be labelled derogatory terms about your sexual behaviour or orientation in our society as MSM either by family, church or community members, or even by healthcare workers who sometimes gossip to their colleagues once they know about your sexual behaviour.

Multiple concurrent partners and short-term relationships were cited by the participants as some of the factors perceived to put MSM at risk of HIV infection. Participants explained that multiple concurrent partnerships are common among the MSM population. They further stated that normally, sexual relationships among MSM are often short term and there is general lack of long-term, monogamous relationships. One participant was quoted as saying:

I think most gay people don't have steady partners. They frequently have new sexual partners. I think the ratio between “top guys” [insertive partners] and

Table 1: Summary of quantitative findings

Findings		<i>n</i> ($N = 35$)	Percentage
<i>Risks and vulnerabilities</i>			
Knowledge on risk of HIV infection	Knowledge of anal sex as the most risky to HIV infection type of sex	5	14
	Knowledge that receptive anal sex carries has high risk of infection than insertive anal sex	7	20
Experiences as a result of being MSM	Have been labelled with derogatory terms by those who knew or suspected he was MSM	29	83
	Feeling rejection because of sexual orientation	20	57
	Been avoided by people they had disclosed their sexual behaviours to, including: friends, family members and health care workers	23	66
Sexual behaviour	Have disclosed their sexual orientation to someone else	31	89
	Have reported having more than one male sexual partner in the last six months	26	74
	Had vaginal sex with a woman in the last six months	8	23
	Always used a condom when having sex with male sexual partners in the last six months	4	34
	Not used a condom the last time they had anal sex with a casual partner	12	34
	Have used female condoms for anal sex with male sexual partners	6	17
	Have difficult or some little access to the lubricants	20	56
<i>Knowledge and perception on other HIV prevention methods</i>			
PrEP	Have heard about PrEP	3	9
	Would uptake PrEP if it was provided	23	66
	Would not use condoms if they were taking PrEP	12	34
	Would prefer PrEP to be provided by health care worker	17	49
Rectal microbicides	Have heard about rectal microbicides	0	0
	Would uptake rectal microbicides if it was provided	29	83

“bottom guys” (receptive partners) is huge. There are few top guys and therefore the bottom guys always share the top guys. Most gay people end up dating straight guys.

Because of an imbalance of power between insertive and receptive sexual partners, which is associated with being a receptive partner perceived as less powerful and submissive to the perceived more manly insertive partner, some of the receptive participants reported that decisions around condom use were frequently made by the insertive partner, colloquially referred to as the “top guy”. The respondents explained that the insertive partner typically has the status of a decision maker. One respondent further explained:

As a receptive partner, you don't want to miss a chance of having fun with an insertive partner. So when he approaches you and decides against a condom, you are likely to go on having sex with him without using the condom.

Risks for and vulnerabilities to HIV infection among MSM: societal factors

Participants reported perceived and experienced stigma at healthcare facilities from healthcare workers. They stated that healthcare facilities always have hetero-normative settings and it is not easy for a man who has sex with other men to talk about same-sex issues, especially anal health. As a result, most MSM do not disclose their true sexual behaviour to healthcare workers. Participants added that most MSM fear, and therefore, avoid seeking health care because of the expectation of health worker stigma. One of the participants gave an example:

Most of us end up trying other remedies in private if we have health problems, especially if they are anal related. It is not easy to go and tell a health care worker that I have an illness from having sex with other men. I really don't know how they can think of me. The problem is that these people come from the same societies where we come from. They come from our churches and other institutions where we live and they are possibly our relatives or friends to our relatives sometimes.

Adding to the fear of seeking healthcare services was the size of the country. Swaziland is a small country and respondents felt that one was likely to meet someone he knows when seeking health care. As one MSM further explained:

Even buying water-based lubricant from a shop is a problem. People look at you and you can see they are questioning. The big problem is that you never know when you will meet someone you know.

There is lack of support from family members and society at large. Participants stated that such lack of social support results in poor decisions and choices.

Suggested HIV prevention strategies among MSM by participants

Participants suggested several prevention strategies for MSM, including, expanding peer education programmes: most MSM prefer to receive information and services from their peers on the grounds that a peer educator would not be prejudiced against them. For example, in the quantitative

findings respondents (44%, $n = 16/35$) reported accessing condoms through peer educators as it was easier for them. They further suggested safe spaces where they can meet without fear and have access to information and services. They suggested having regional centres (country-wide) exclusively for MSM needs where they can meet and mentor each other; share their experiences; access health information, condoms and lubricants; and get professional and relationship counselling to reduce short-term relationships and multiple partners.

With the lack of social support, participants suggested that there is a need to increase public awareness of the existence of MSM and the issues around them to leverage support families and society at large. They suggested public awareness could be increased by including topics on anal sex and bisexuality public health education as they cut across the general population. Participants suggested healthcare workers should be also sensitised on MSM issues and suggested healthcare settings should be inclusive of MSM sex education. This should be visible even from the information, education and communication material available at these centres. Participants stated that this can reduce stigma, and inform the general public about MSM. One MSM participant stated:

The Ministry of Health and other organisations should start including topics like “anal sex” and “bisexuality” in public health education. These practices do not occur only within the MSM population but also in the general population. People would start to listen because these practices also happen to their sexuality. This can raise awareness about MSM behaviour while acting as a link between MSM sexual behaviour and that of heterosexuals.

Participants suggested that venues frequented by MSM should be targeted with condoms and lubricants. Night clubs were reported to be the most frequented venue. Respondents stated that these are venues where most “unplanned” sex occurs. They suggested that the condoms and lubricants should be packed in a way that will promote use of both condoms and lubricants, for example, packing both commodities together in the same packages. One young MSM respondent stated:

Condoms and lubricants should be made available to everyone despite sexual orientation as the extent of their need varies. There are so many heterosexual couples that engage in anal sex and they also need lubricants.

Discussion

A key finding was the ongoing risk of HIV infection and vulnerability of MSM due to individual and structural factors. MSM still face multiple layers of individual and social factors that put them at higher risk of HIV exposure. One of the structural issues in Swaziland is the high level of stigma towards same-sex behaviour which often causes individual MSM not to disclose their true sexual behaviour, especially to healthcare workers. Although most, 89% (31/35), of the MSM respondents had disclosed their sexual orientation, most of them 90% (28/31) would only disclose to a friend, who in most cases was also MSM. They were not likely to

disclose to a healthcare worker even when seeking services related to their sexual behaviour. For example, only 16% (5/31) had disclosed to a healthcare worker. These findings are in line with those from previous studies which highlighted association with fear of seeking health care as a result of same-sex orientation or practice and with disclosure of same-sex practices for MSM in Swaziland (Risher et al., 2014). Yet disclosure of sexual orientation or practices to a healthcare provider is an important step in the provision of appropriate health care for MSM so that they receive appropriate services (Mayer et al., 2012).

Although MSM expressed a need for support from friends, family members and healthcare providers, they were fearful of being stigmatised and rejected if they disclosed their sexual orientation. MSM who disclosed their sexual behaviours or orientations to family members were put under pressure by family members to change their sexual behaviours.

The fear of perceived and experienced stigma noted in the study has been also highlighted in previous studies on MSM in Swaziland. Kennedy (2013) found significant and multiple forms of stigma discrimination among MSM, and dual stigma to those living with HIV. Kennedy noted that such fear of stigma and rejection led to lack of disclosure in fear of negative reactions and rejection among MSM. Stigma and lack of support have a direct impact on an individual's sense of worth and reduces a person's motivation to protect himself or others from high-risk sexual behaviour (LINKAGES, 2017).

The study also noted that experiences of being stigmatised and fear of disclosure were associated with feeling guilty about sexual orientation among MSM. Most MSM respondents (63%) felt guilty about their sexual orientation. Poor mental health has been associated with sexual stigma and stress elsewhere (Mayer et al., 2012). Social and mental care is essential for all MSM and other key populations. This has also been emphasised as an important intervention for MSM elsewhere (WHO, 2014).

A surprising finding for the researcher, though it should have been expected in view of the "hidden" life of MSM in Swaziland, was the limited knowledge and the misconceptions about anal sex and the risk of HIV amongst the MSM who participated in the study. Nonetheless, the lack of knowledge is cause for concern. Most MSM did not know anal sex has higher HIV infection risk than vaginal sex. These beliefs contradict research which has shown that receptive anal sex has the highest risk of HIV transmission (CDC, 2016). Secondly, the research revealed limited knowledge amongst the study participants on PrEP and rectal microbicides, which are means to prevent HIV infection. Although this intervention (PrEP) has only recently started as a pilot in Swaziland, there was no knowledge about it among MSM.

The lack of "protective" knowledge amongst the MSM contrasts sharply with their proclivity for high-risk sexual behaviour. As recorded earlier in this paper, multiple concurrent sexual relationships and short-term relationships were common in this sample of MSM.

The findings highlight other HIV risk factors for MSM, especially younger MSM. While older MSM were the most hidden and few participated in this study, as is the case with

other studies in Swaziland, the findings show younger MSM (below age 30) often have organised party gatherings and where they engage in sex without use of condoms (in part because condoms are not available at the social venues they frequent). Inconsistent use of condoms among MSM has been observed in other studies in sub-Saharan Africa where, in some cases, MSM use condoms when engaging in vaginal sex (Msinguzi, 2015). This research highlighted other factors that should be included in interventions to reach MSM, especially in high stigma environments. Notably, peer education, which employs MSM educators, seems to be an essential foundation as MSM were comfortable receiving basic HIV prevention services from their peers.

Additional related components for interventions include establishing "safe" spaces for MSM to be educated and to obtain information in a space where they will be comfortable to meet. The MSM participants stated the need to increase public awareness about MSM health needs, decreasing homophobic-related stigma and discrimination. The MSM participants therefore suggested that hetero-normative settings at healthcare facilities should incorporate the health needs of MSM by sensitising healthcare workers, and having information, education and communication material that includes MSM health. They further suggested public health education that is not hetero-normative. There is therefore a need to sensitise or train healthcare workers both as part of their tertiary training in medical schools and/or in-service.

Internet-based information was indicated as a communication need by the MSM sample. Nearly 80% of the respondents preferred to access HIV prevention information for MSM through the Internet, as they stated that it was easy to access and it afforded them privacy. This is in line with findings from previous studies suggesting Internet-based interventions because they can also provide a promising HIV information delivery mechanism. Stahlman et al. (2015) indicate that the prevalence of MSM seeking online sex partners is 43.8% among MSM in Swaziland and they could be reached through this intervention. The need for Internet-based HIV prevention information in line with the WHO (2014) report that Internet-based HIV prevention interventions make it easier for MSM with Internet access to obtain relevant HIV prevention messages anonymously, at a convenient time and in private, especially in setting where there is a lot of homophobic stigma.

Improving the strategies for providing information and content of information for MSM on Ministry of Health and health NGO websites could be a simple but important intervention as it was clear most MSM had access and prefer Internet-based information.

Conclusions

Few empirical studies on MSM exist in Swaziland. This study was exploratory, but it was designed to provide insight into the lived experiences of MSM. Although the Government of the Kingdom of Swaziland recently initiated interventions for key populations, including MSM, many gaps remain in information on HIV prevention needs of the MSM population in the country. Officials and HIV programme designers lack information on what to include in interventions. Programmes in Swaziland should consider tailored multi-level interventions

that address these unique needs at the policy, societal, key population community and healthcare delivery levels. While there should be programmes focusing on sensitisation and training of healthcare workers on key populations issues from pre- and post-service levels for competence and being receptive to key populations, much work still needs to be done at MSM community and policy levels.

There is need to increase access to specific information and services for MSM through community empowerment. MSM have community-based organisation and peer educators. There is a need for these to be strengthened and be part of service provision to MSM. There is also need to create “safe spaces” such as “drop-in centres” to increase service delivery points for MSM in venues where they will be more comfortable. Internet-based interventions are also important in reaching MSM who otherwise would not be reached through traditional interventions. Policies that are inclusive of MSM and other marginalised populations which are at high risk are necessary to the Government of the Kingdom of Swaziland. Research to increase knowledge on the experiences and needs of MSM is also important.

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