



REFLECTIONS

Providing HIV care to men who have sex with men in South African state sector clinics

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South Africa's mass rollout of antiretroviral therapy (ART) a decade ago changed the face of the AIDS epidemic in the country. Various populations have, however, not benefited equally.

Treatment programmes have been successful in reaching women, who make up two-thirds of those receiving treatment in state sector clinics, but less so in reaching men.^[1] This is even more apparent for South African men who have sex with men (MSM), who have historically been ignored for directed service provision, despite being a key population at high risk of HIV acquisition and transmission.

HIV prevalence among local MSM has been estimated at 10 - 43% in various studies.^[2-5] Until fairly recently, local and regional data were unavailable to inform targeted and appropriate health programming for this population group. South Africa's enabling constitution and government's (SAG's) commitment to providing appropriate care to key populations, including MSM, has provided an opportunity to gather data and develop and implement evidence-based health services.

Anova Health Institute, in partnership with the provincial Departments of Health (DoHs) and with support and funding from the President's Emergency Plan for AIDS Relief (PEPFAR)/United States Agency for International Development (USAID) launched Health4Men, the first state sector programme aimed at addressing MSM sexual health and wellness.^[6] The programme includes limited 'centres of excellence' in Cape Town and Johannesburg where large cohorts of MSM can receive direct health services. Data collected from these cohorts are used to develop, test and refine locally responsive and appropriate management guidelines. Operational research is also conducted at these sites, aimed at improving the quality of service and providing the SAG with data to assist in future health planning.

Although important, such centres of excellence are expensive and not scalable. Therefore, the core activity advocated by the Anova model is widespread sensitivity and skills training for healthcare workers already active in state sector HIV, sexually transmitted infection (STI), tuberculosis (TB) and primary health clinics. The aim is to enable them to provide appropriate care for their MSM patients, based on local guidance developed by centres of excellence.^[7] This competency training has occurred

in four provinces thus far, with plans to roll out nationally in the near future. Currently, six MSM-competent clinics are supported by this project, and many lessons have been learnt from the experience in the field.

Services for MSM can only exist with buy-in from multiple stakeholders. The SAG and provincial DoHs have been responsive to the health needs of MSM at a high level, and have included targeted health services in the country's national and provincial strategic plans. Local HIV, AIDS STI and TB (HAST) managers have mostly been supportive of integrating MSM healthcare skills into their current facilities. Training has been well received by state clinics and MSM training has been approved and integrated into provincial regional training centres. International donors such as PEPFAR/USAID and the Global Fund have developed normative guidance on developing and implementing MSM-targeted services and have been willing to fund such initiatives. Civil society has been able to influence local policy through representation via the lesbian, gay, bisexual, transgender and intersex (LGBTI) sector in the South African National AIDS Council (SANAC). Strong community engagement with groupings of gay/other MSM has created a demand for targeted HIV and sexual health initiatives.

Anova's experience has identified certain factors that facilitate attracting MSM to healthcare services, retaining them for chronic care and reducing HIV and STI transmission risks:

- **HIV services:** Screening for HIV (HIV counselling and testing) should include MSM-sensitive counselling. Counsellors who adopt a judgmental, heteronormative attitude risk alienating clients, thus negating the benefits of counselling. Many counsellors do not ask men if they have same-sex partners and assume only female partners. This results in inappropriate service delivery, resource and time wastage (e.g. no risk reduction occurs if MSM receive counselling on safe penile-vaginal sex but they do not engage in that activity). MSM attending services are particularly concerned about the confidentiality of their information, specifically their sexual orientation and HIV status, and need to be convinced that their private information is adequately protected.
- **HIV treatment services:** MSM should be treated according to the National DoH's ART guidelines, as for any other adult, with a few additional considerations. Due to the efficiency of

HIV transmission during unprotected anal sex (approximately 18 times that of unprotected penile-vaginal sex^[8]), early treatment should be considered even at high CD4⁺ counts to prevent onward transmission of infection, i.e. treatment as prevention. Some subsets of MSM are extremely body-conscious and will not adhere to medications that cause visible side-effects, such as lipodystrophy. One also needs to consider drug interactions with anabolic steroids and other supplements in this body-conscious group. ART agents that cause diarrhoea as a side-effect may cause sexual dysfunction in MSM who engage in receptive anal sex. Adherence support is often complex due to a lack of family support. Substance and alcohol abuse and mental health problems such as anxiety and depression are more prevalent among MSM than heterosexual men. Of importance is that MSM status does not cause mental illness; rather, that depression and anxiety result from the constant stress of being marginalised and stigmatised.^[9]

- **STIs:** A significant proportion of visits to many MSM clinics are for STIs other than HIV. STI symptoms are a common reason for seeking healthcare in this key population. This should be leveraged in healthcare messaging to attract men into care. Once they attend a clinic, an opportunity for risk-reduction counselling and HIV screening arises. STIs are treated locally according to governmental guidance, which advocates for empirical treatment of various syndromes such as genital discharge or genital ulcer syndromes.^[10] Attempts to identify the aetiology of the infection and determine antibiotic sensitivity are not advocated. These guidelines are not responsive to the needs of MSM and will likely be ineffective. This is because most cases of gonorrhoea and chlamydia are asymptomatic in MSM and the rate of cephalosporin-resistant gonococcus is higher than in heterosexual men and women.^[11] The guidelines do not encourage healthcare workers to consider oro-pharyngeal and anal STIs in men.
- **HIV-prevention services:** MSM attending many clinics have reported difficulty in accessing post-exposure prophylaxis (PEP) from mainstream state health services, and many barriers have been identified. These include: most PEP is required after hours when experienced HIV clinics are closed; the need to be screened for HIV (often performed by MSM-insensitive staff who are unable to provide appropriate counselling); and the myth that PEP is only available in state clinics for the prevention of nosocomial HIV or following sexual assault. We firmly advocate for PEP following sexual assault and it is not the onus of a health provider to determine whether or not sexual exposure was consensual.
- **Pre-exposure prophylaxis (PrEP):** PrEP with tenofovir plus emtricitabine is potentially extremely effective at preventing HIV transmission.^[12] High HIV-risk populations such as MSM, commercial sex workers, drug users and negative partners in discordant relationships should be offered PrEP. PrEP is being offered in the private sector, but no services exist in the state sector; this is an omission that should be addressed.
- **Medical male circumcision (MMC):** This is an effective intervention for preventing HIV in heterosexual men and has been taken to scale by the SAG. Unfortunately, this intervention is less effective in MSM as their main route of HIV infection is receptive anal sex, where circumcision status plays no role. However, there is robust evidence that approximately half of South African MSM also have sex with women and they would derive risk-reduction benefits during such encounters. MMC should therefore be offered to all men, irrespective of sexual orientation, but education and information needs to be nuanced correctly so that men understand the benefits and deficiencies of the procedure.^[13]

Underlying all of this, community engagement is essential to the success of MSM-targeted health provision. Many local MSM are fearful of health-provider stigma and avoid health services, even if their perception is unfounded. Peer educators and health ambassadors should be deployed to inform MSM of their human and healthcare rights, and to promote access to clinics that have received MSM sensitivity and skills competency training. Community upliftment programmes aimed at raising the social capital of the most marginalised MSM are important.

The Anova Health4men experience has led to the production of a variety of tools that could be adopted by mainstream state sector HIV/ART clinics. These include, among others: appropriately branded condoms and sexual lubricants, information and educational communication materials and instructive manuals for health providers. Anova has made use of a number of technology-lead health initiatives such as its website (<http://www.health4men.co.za>), smartphone site (<http://h4m.mobi>) and a variety of online health and health satisfaction surveys.

We applaud the SAG's current willingness to engage with MSM healthcare and the inclusion of targeted services in our country's health plans. This is especially relevant on the African continent where the attitude of the SAG stands in stark contrast to countries such as Nigeria, Uganda and Zimbabwe, where persecution of gay and other MSM is legally and politically sanctioned and where targeted services providing ART to MSM are almost impossible. We anticipate that the fruitful partnership between the SAG and Anova, as well as other non-governmental organisations active in this field, will continue to allow South Africa to take the lead in providing HIV and ART services to all citizens as a basic human right, in the absence of stigma and judgement.

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