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The Johannesburg/ eThekweni Men's Study (JEMS)

*A Rapid Assessment of the HIV Epidemic among
Men who have Sex with Men (MSM)*



Information Leaflet

**Durban
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Why the study?

South Africa (SA) is experiencing a generalised HIV epidemic, with approximately 5.5 million people living with HIV, the largest number of HIV infections in any country in the world. Recent evidence suggests that, even in countries with generalised HIV epidemics, the risk of acquiring HIV infection is usually considerably higher in men who have sex with men (MSM) than in men in the general population.

We identified a need to implement HIV surveillance and to address gaps in knowledge of the HIV epidemic among MSM in South Africa in 2006. Subsequently, the *National Strategic Plan on HIV & AIDS and STIs, 2007 – 2011* (NSP) drew attention to the need for surveillance, and policies and programmes for most-at-risk populations, including MSM. The need for information on HIV among MSM was further highlighted by the failure to include any of the standard UNGASS indicators pertaining to MSM in the South African country report submitted to the United Nations at the beginning of 2008.

We set out to do a rapid assessment of HIV among MSM in Johannesburg and Durban (eThekweni) as a first step towards implementing national HIV surveillance among MSM. We named this study the Johannesburg/ eThekweni Men's Study (JEMS). The aims of the study were to provide preliminary information on the epidemiology of HIV among MSM in Johannesburg and eThekweni (Durban), and to review the availability of programmes and services to MSM. Our study focused on men who had sex with men, irrespective of whether or not they also had sex with women, or whether or not they identified as homosexual or gay.

Who carried out the study?

The study was a collaborative effort between the Centre for Health Policy at the University of the Witwatersrand, the Human Sciences Research Council (HSRC), and the Medical Research Council (MRC). The research team were led by Prof. Laetitia Rispel and Dr. Carol Metcalf.

Where was the study done?

We conducted the study in Johannesburg and Durban because they are two large cities with diverse populations, located in two different provinces of South Africa. In planning the study, we tried not to compete with other ongoing or planned research on MSM in Cape Town and Pretoria, even though most of the researchers were based in these two cities and surveys of MSM conducted for UNGASS surveillance purposes are usually conducted in the country's capital city.

How was the study done?

The study had 4 components: (1) A review of published and unpublished information on HIV among MSM in South Africa; (2) interviews with experts ("key informant interviews"); (3) focus group discussions with MSM; and (4) a survey of HIV and behaviour among MSM.

The study was approved by Research Ethics Committees at the HSRC and the University of the Witwatersrand. Prior to the study, an initial consultative meeting was held with key stakeholders, including Lesbian, Gay, Bisexual, Transgender (LGBT) representatives. A steering committee was established to advise the researchers. This committee met twice during the study.

A combination of qualitative and quantitative methods was used. Semi-structured interviews were conducted with 32 key informants in Gauteng, KwaZulu-Natal, and Cape Town to get advice about conducting research among MSM, to assess the availability of services and programmes for MSM, and to find out about other recent or ongoing research on HIV among

MSM that had not yet been published. 18 focus group discussions were held with MSM in Johannesburg, Durban and Cape Town to gather information on issues of identity, meeting places and networks, risk behaviours and HIV service access and needs.

MSM in Johannesburg and Durban were recruited into a survey of HIV prevalence and behaviour using respondent-driven sampling (RDS). RDS is a form of chain sampling, used to recruit members of “hard-to-reach” populations. It has been extensively used in other countries for similar surveys of HIV among MSM. Under optimal circumstances, RDS enables one to get a “representative sample” of a specific group, even when most members of the group being sampled have not been identified.

Survey participants completed a detailed questionnaire and provided finger-prick blood specimens for HIV testing of dried blood spots in a laboratory. A total of 285 men were recruited into the study, 204 in Johannesburg, and 81 in Durban. Both the questionnaire and the HIV testing were anonymous, but the questionnaire results were linked to the HIV results using a unique identifying number assigned to each participant. In addition, all survey participants were offered voluntary counselling and HIV testing (VCT) with pre- and post-test counselling.

A preliminary analysis has been done of the survey results. A weighted HIV prevalence estimate was calculated using RDSAT, a software programme for analyzing data from RDS surveys. The weighted HIV prevalence adjusts for the tendency of people to recruit people similar to themselves. More sophisticated analyses are in progress. We plan adjust the results to take into account factors such as age, which may skew associations observed between “risk factors” and HIV status.

What were the main findings?

Some of the qualitative research findings from the key informant interviews and focus group discussions were:

- Among MSM, sexual networks and social networks overlap, but sexual networks tend to be more transient with many casual sexual encounters. Social networks tend to be racially segregated; sexual networks probably less so. Physical venues for meeting men are increasingly being replaced by the use of technology, such as the internet (e.g. Gaydar) and cell phones (e.g. MxIt).
- Risky sexual behaviour such as unprotected anal intercourse (UAI) is widespread. Misperceptions and lack of information (e.g. about risks associated with anal sex and unsafe lubricants) contributes to HIV risk. Alcohol and drug use are important predisposing factors to engaging in risky sex.
- MSM continue to face stigma, discrimination and a lack of acceptance from society, including health care workers. This may affect their willingness to seek health care, and to give full and accurate health histories, and may also affect their relationships with other men.
- MSM are reluctant to be tested for HIV for a variety of reasons including a low risk perception and denial of risk, fear of HIV and fear of being “outed”, and judgmental attitudes of health workers.
- HIV prevention, treatment and care services tailored to MSM are not widely available. Mainstream public sector health services are inadequate and tend to be insensitive and unresponsive to the needs of MSM.

We found that RDS could be used to recruit MSM into the HIV prevalence and behaviour survey, but that it was more challenging and took longer than anticipated. 285 men participated in the survey (204 from Johannesburg, and 81 from Durban). Participants' age ranged from 18 years to 61 years, with a median (midpoint) age of 22 years and a mean (average) age of 24.5 years. Overall, 88% of participants were black Africans, and 67% were under the age of 25 years. Of the participants, 78% reported being homosexual/gay and

19% reported being bisexual. Only 36% had ever had sex with a woman, and only 7.5% had a main partner who was female at the time of the survey.

HIV prevalence

The overall HIV prevalence among the 266 men tested was 43.6% (95% confidence interval [CI]: 37.6% – 49.6%). The weighted HIV prevalence, using RDSAT to adjust for sampling HIV prevalence estimated for men in the general population based on the 2005 national household HIV survey (11.7%) or the Actuarial Society of South Africa (ASSA) 2008 estimate (15.5%) (Figure).

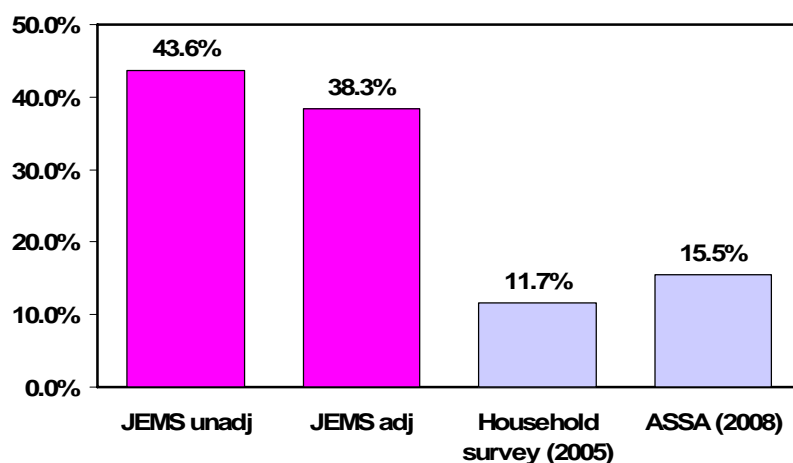


Figure: HIV prevalence among JEMS participants compared to men in the general population

Sexual and other risk factors for HIV infection

Men in the survey reported having up to 60 male sexual partners in the past 12 months, with HIV-positive men tending to have more partners (mean 7.5, median 3) than those who were HIV-negative (mean 5.0, median 2). Overall, 46% of participants reported having unprotected anal intercourse (UAI) in the past 12 months; 30% reported UAI with someone with an unknown HIV status; and 4% reporting UAI with someone HIV-positive in the past 12 months. Compared to HIV-negative participants, HIV-positive participants were significantly more likely to have had UAI (58% vs 39%). HIV-positive participants were also significantly more likely to have had UAI with someone who they knew to be HIV-positive in the past 12 months (22% vs 8.7%), suggesting that there may be some degree of serosorting (choosing sexual partners with the same HIV status as oneself).

Condom use and lubricant (lube) use: Experiences of condom unavailability and condom accidents were reported by many survey participants, with 55% reporting not having a condom available when they needed one, 42% reporting at least one instance of condom slippage, and 58% reporting an instance of condom breakage in the past 12 months. Many participants reported having used substances that reduce the protective effect of condoms as lubricants with a condom, including Vaseline (32%) and lotion (28%).

Alcohol and drugs may play a role in sexual risk behaviour. 73% of survey participants reported having had sex while under the influence of alcohol, but only 11% reported having had sex while under the influence of drugs in the past 12 months, with no major differences by HIV status.

Transactional sex (i.e. being given or having received money, goods or favours in exchange for sex) was common, with 29% reporting having **given** a man money, goods or favours, and 43% reporting having **received** money, goods or favours in exchange for sex in the past 12 months. Sexual coercion was also common, with 36% of participants reporting having had sex with someone against their will, and 29% reporting that they had made

someone have sex with them against that person's will at some stage in the past. Compared to HIV-negative participants, HIV-positive participants were significantly more likely to have been made to have sex with someone against their will (47% vs 30%).

Compared to HIV-negative participants, HIV-positive participants were **significantly less** likely to have had **sex with a woman** ever (20% vs 48%), or in the past year (3.5% vs 27%); were significantly less likely to have a female main partner (1.7% vs 13%); and were significantly more likely to identify as homosexual/gay (94% vs 66%). This suggests that the HIV epidemic among MSM in South Africa is a parallel epidemic to the general HIV epidemic, with limited overlap between the 2 epidemics.

HIV testing and knowledge and disclosure of HIV status

Knowledge and disclosure of HIV status was limited. Although 97.9% of survey participants knew where they could be tested for HIV, only 47.5% had been tested for HIV in the past year and given the result. Only 25 of 282 participants (8.9%) accepted the VCT that was offered as part of the survey. Of all participants, 57% reported that they "knew" their HIV status, but we did not check whether their belief about their HIV status corresponded with their true HIV status. Of those who knew their status, only 69% had disclosed their status to a sexual partner in the past 12 months.

Availability and utilisation of health services for MSM

Of survey participants, 57% had used **public sector health services** in the past 12 months and only 31% reported having medical aid coverage. Only 6.8% participants expressed a preference for receiving HIV prevention services from a government clinic. Almost all participants expressed an interest in attending a workshop (97%) or individual counselling (92%) on how MSM can prevent themselves and their partners from getting HIV, suggesting that some of the reluctance to be tested may be due to fear or denial, rather than a true lack of awareness that MSM are at risk of HIV infection.

Recommendations

The JEMS findings should be used to inform the South African HIV response outlined in the NSP. The recommendations listed below are premised on the critical role of government in providing overall leadership to achieve the objectives of the NSP.

Recommendation 1: Establish an ongoing surveillance system

The government ought to take responsibility for developing an ongoing surveillance system for most-at-risk populations, including MSM. The survey instruments provide a foundation on which to build. Further research and debate is needed in order to assess optimal methods of sampling MSM for surveillance purposes. Particular attention needs to be given to finding ways of increasing racial, socioeconomic, and age diversity and expanding geographic coverage when conducting surveillance of HIV among MSM in South Africa.

Recommendation 2: Develop a minimum package of services

Although the NSP was approved in 2007, to date there has to date been little practical action to implement a minimum package of services for MSM. A minimum package of services should include, at least:

- Targeted and specific information, education and communication (IEC) about the risks associated with unprotected anal sex, promotion of correct and consistent condom use, and information about the types of lubricants to be avoided;
- Condom promotion and social marketing; improving condom availability and distribution to non-health facilities; and providing safe water-based lubricants (e.g. KY Gel);
- STI diagnosis and treatment and HIV treatment, care and support services;

- Behavioural interventions to decrease the practice of risky sexual behaviour, and to address substance use, particularly alcohol use, because risky sexual behaviour often takes place when under the influence of alcohol or drugs.

Recommendation 3: Promote HIV testing, and knowledge and disclosure of HIV status

The need to promote HIV testing, and knowledge and disclosure of HIV status is core to achieving the two main goals of the NSP (reducing HIV incidence by 50% and ensuring that at least 80% have access to HIV treatment by 2011). As MSM are disproportionately at risk of HIV infection and have been ignored in national campaigns, urgent attention needs to be given to addressing this programme gap. We recommend that a national campaign should be developed and implemented in partnership with LGBT organisations to promote HIV testing, and knowledge and disclosure of HIV status among MSM.

Recommendation 4: Improve responsiveness of the health system to the health care needs of MSM

Public sector health services need to become more welcoming and accepting towards sexual minorities. The education of health care professionals, including those working at the primary care level and within STI clinics and HIV testing and counselling sites, is essential to overcome ignorance and prejudice about MSM. Heterosexuality should not be assumed by health service providers. Appropriate clinical guidelines should be developed to guide health care workers in caring for sexual minorities, drawing on experience from other countries. However, as many MSM feel more comfortable using services specifically targeting MSM, financial resources and /or technical support for LGBT organisations that provide health services should also be increased.

Recommendation 5: Address the social and structural determinants that make MSM vulnerable to HIV infection

We recommend that greater attention be paid to enforcing a human rights culture in all aspects of HIV management. Article 25 of the Universal Declaration of Human Rights guarantees the right to medical care and necessary social services. Steps that can be taken are to ensure that all policymakers and health-care providers are familiar with Article 25 and that posters be displayed prominently in health care facilities. Stigma, discrimination and homophobia are obstacles to HIV epidemic management. In line with the recommendation from the 2008 International AIDS conference, we recommend that a higher priority be accorded to anti-stigma and anti-discrimination policy and programme development, and that these programmes be adequately resourced.

Conclusion

Although the results of JEMS cannot be generalised to all MSM in South Africa or even to MSM in the two study cities, these findings suggest that MSM are disproportionately affected by HIV, and that there is a “hidden epidemic” of HIV among MSM, in keeping with studies conducted in other countries with generalised HIV epidemics.

The NSP provides an overall framework that includes all the elements necessary for an effective HIV and AIDS response. The JEMS findings, albeit limited to the sample of men in the two cities, provide important insights into the epidemiology of HIV among MSM and the risk factors that should be addressed. The findings suggest that there is no scope for complacency and the focus must be on urgent programme implementation, responsive to MSM needs.

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