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MSM IN SOUTH AFRICA

Data Triangulation Project



Global Health
Sciences
Global Strategic Information

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Preface

In a perfect world, HIV would not continue to evade the collective efforts of the most talented scientific minds on the planet, the most dedicated and skilled health professionals and programme implementers in our field, and the enormous financial resources that humanity has collectively deployed against the global pandemic. In a slightly less-than-perfect world where HIV continued to exist, HIV programmes and policies would be guided by abundant data of the highest quality, generated rapidly through rigorous, methodologically consistent scientific studies with clearly interpretable results, collectively showing unambiguous trends that would point clearly to the most effective and efficient course of action.

We live and work in neither of those worlds. While we wait for scientific research to definitively answer our most pressing questions about what factors drive the HIV epidemic and how to intervene most effectively, we often must work with less-than-perfect information in less-than-ideal quantities to make decisions about how to implement and fund the public health programmes that will, at least, maintain the life and health of our families, friends, and communities.

Perhaps nowhere is the gap between the data we need and the data available to us greater than in concentrated HIV epidemics among key populations in low and middle-income countries of Sub-Saharan Africa: men who have sex with other men (MSM); persons of transgender experience, especially transgender women; sex workers—female, male, and transgender-identified; and persons who inject drugs (PWID). The reasons for this are many, including the magnitude of resources required to address generalized epidemics; but also, unfortunately, due to abuses of human rights and criminalization of behaviours that place individual members of these key populations at high risk of infection and onward transmission.

South Africa has prioritized addressing the HIV epidemic among key populations in its current 2012-2016 HIV/AIDS National Strategic Plan (NSP), recognizing the disproportionate burden of HIV carried by each of the key populations named above. Owing to South Africa's favourable human rights-based legal framework with respect to sexual orientation and gender identity, HIV research and programming with MSM has taken off in South Africa over the last decade and begun to build what is perhaps the strongest evidence base for addressing HIV among any key population in South Africa and throughout the sub-Saharan region. Yet, these efforts have not been coordinated through strategic planning. Rather, they have largely been undertaken by individual academic researchers, government- and non-governmental health services providers, financed largely by international institutions, and used heterogeneous methodologies, instruments, and monitoring and evaluation (M&E) frameworks. Nor, to our knowledge, has the growing body of MSM research and programme M&E data been systematically explored by South African governmental and civil society stakeholders to assess the status of the current national response, and appropriately plan and finance future public health action.

In December 2013, the University of California San Francisco, in partnership with the South African National Department of Health (NDOH) the South African National AIDS Council Trust (SANAC Trust) and MSM programme and research stakeholders, agreed to launch a data triangulation and synthesis activity to better understand the state of and response to the HIV epidemic among MSM in South Africa.

With the support of the US President's Emergency Response for AIDS Relief (PEPFAR) through the US Centers for Disease Control and Prevention's South Africa office (CDC-SA), over the last fourteen months we have collectively catalogued and analysed over 300 diverse sources of existing MSM research and programme data generated in South Africa between 2008 and 2013.

In this report of the South Africa MSM Data Triangulation Project, we describe our systematic exploration and synthesis of these data, the trends observed in the epidemic and national response with respect to MSM, and critical data gaps identified. Finally, we offer our conclusions and recommendations for short- and long-term action.

We hope the information contained is interesting and useful to readers in South Africa and beyond. The greatest value of this triangulation report will be realized as its findings and recommendations are incorporated into actionable plans to end the epidemic among MSM through the prevention of new HIV infections and effective clinical management of those currently living with HIV.

Timothy Lane, PhD MPH

University of California, San Francisco

Center for AIDS Prevention Studies

Global Health Sciences/Global Strategic Information

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Technical Working Group

Michael Grasso, Andrew Scheibe, Amanda Zhou, Sibongile Dladla, Edward Vallejo, John Imrie, Dawie Nel, Tonderayi Macheke, Benjamin Janse van Rensburg, Jacques Livingston, Joseph Daniels, Albert Manyuchi, Keletso Makofane, Thandiwe Mzimela, Renugan Raidoo, Glenn de Swardt, Kevin Rebe, Eva Marumo, Helen Savva, Theo Sandfort, Nondumiso Makhunga-Ramfelo, James McIntyre, Musa Mabaso, Celeste Sauls, Ben Brown, Rob Hamilton, Paige Neuenschwander and Zachary Isdahl.

Writing Group

Andrew Scheibe, Michael Grasso, Rob Hamilton, Zachary Isdahl, Helen Struthers, Tom Osmand, Amanda Zhou, Edward Vallejo, Kevin Rebe, Eva Marumo, John Imrie, Tonderayi Macheke, Dawie Nel, Renugan Raidoo, Tim Lane and Ben Brown.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ATS	Amphetamine-type stimulants
BCI	Behaviour change intervention
CatID	Catalogue Identification Code
CBO	Community based organisation
CDC	Centers for Disease Control & Prevention
COC	Cultuur en Ontspanningscentrum
CT	Cape Town
DOH	Department of Health
DTHF	Desmond Tutu HIV Foundation
EC	Eastern Cape
EH	Ehlanzeni
EJAF	Elton John AIDS Foundation
FGD	Focus group discussion
FHI	Family Health International
FS	Free State
GS	Gert Sibande
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	Gauteng
GSI	Global strategic information
HBV	Hepatitis B
HCT	HIV counselling and testing
HCV	Hepatitis C
HCW	Health care worker
HH	Household
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HTA	High transmission area
ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, education and communication
JHB	Johannesburg
JHSPH	Johns Hopkins Bloomberg School of Public Health
KP	Key population
KZN	KwaZulu-Natal
LGBTI	Lesbian, gay, bisexual, transgender, intersex
LP	Limpopo
M&E	Monitoring and Evaluation
MP	Mpumalanga
MPMS	Mpumalanga Men's Study

MSM	Men who have sex with men
MSMW	Men who have sex with men and women
NACOSA	Networking HIV, AIDS Community of South Africa
NC	Northern Cape
NDOH	National Department of Health
NSP	National Strategic Plan
NW	North West Province
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
PTA	Pretoria
RDS	Respondent-driven sampling
SAG	South Africa Government
SANAC	South African National AIDS Council
SES	Socioeconomic status
SHIPP	Sexual HIV Prevention Program
SI	Strategic information
STI	Sexually transmitted infection
SWT	Soweto
TasP	Treatment as prevention
TB	Tuberculosis
TWG	Technical Working Group
UAI	Unprotected anal intercourse
UCLA	University of California, Los Angeles
UCSF	University of California, San Francisco
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary counselling and testing
VDRL test	Venereal disease research laboratory test
WC	Western Cape
WHO	World Health Organization

Key Terms

Catalogue Identification Code	A unique alphanumeric code allocated to data sources that were identified and analysed as part of the triangulation process.
Concentrated HIV epidemic	HIV exists in more than 5% of a sub-population or key population such as MSM.
Convenience sampling	A statistical method of selecting people because of the ease of their volunteering or selecting units because of their availability or easy access.
Data catalogue	Database of mined data, organized by type of data source, with sub-categories referencing other salient information.
Data mining	Process in identifying and collecting available and relevant data.
External condom	Commonly known as the standard male condom.
Generalized HIV epidemic	HIV exists in 1% or more of the general population.
Harm reduction strategies	Approaches intended to manage and reduce consequences of certain risk behaviours.
Heteronormativity	A broad view that promotes heterosexuality as normal or the preferred sexual orientation.
Homophobia	Describes a dislike of or prejudice against people who are sexually attracted to people of the same sex.
Internal condom	Commonly known as the standard female condom.
Key population	Groups, such as MSM, disproportionately infected with HIV compared to the general population.
Men who have sex with men	A behavioural term that refers to sex between people who were born biologically male. The term does not make reference to sexual identity nor sexual orientation.
Post-exposure prophylaxis (PEP)	It involves taking antiretroviral medicines as soon as possible after having been exposed to HIV, to try to reduce the risk of becoming HIV positive. These medicines keep HIV from making copies of itself and spreading through the body.
Pre-exposure prophylaxis (PrEP)	PrEP is the use of prescription drugs for the prevention of HIV infection. It can be taken by people who are HIV negative and who have substantial, higher-than-average risk of HIV infection.
Qualitative data	Data that describes, approximates or characterizes, but does not quantify.
Quantitative data	Data that is quantified and expressed as a number. Examples used in this report include percentages (e.g. HIV prevalence) and counts (e.g. number of condoms distributed).
Respondent-driven sampling	An advanced sampling methodology often used for hard-to-reach populations, combining snowball sampling with a mathematical model to weigh the sample to compensate for non-randomness. This methodology may enhance the representativeness of findings into the wider population.
Treatment as prevention	HIV prevention intervention where treating HIV-positive individual with antiretroviral medicine is used to reduce the risk of transmission of the virus to negative partners.
Triangulation	The synthesis of data from multiple sources for public health decision making. Triangulation includes identifying, collecting, arraying, examining and interpreting data from multiple sources to make evidence-based decisions.
Transactional sex	In the broadest definition, describes the exchange of sex for some form of payment or gift.

Executive Summary

In developing the South Africa National Strategic Plan (NSP) on HIV/AIDS, Sexually Transmitted Infections (STI) and Tuberculosis (TB) 2012-2016, the South African National AIDS Council (SANAC), in partnership with the National Department of Health (NDOH) and HIV stakeholders from around the country and the world, reaffirmed a commitment to addressing South Africa's HIV epidemic among key populations, including men who have sex with men (MSM), transgender women, sex workers, and persons who inject drugs (PWID). The current NSP set ambitious targets for prevention, treatment, and other HIV programming, and called for expanded efforts to collect and utilize strategic information (SI) on key populations to measure progress towards these goals, and set appropriate targets for future planning.

At the time the NSP was developed in 2011, more SI data existed on MSM than on any other key population. These data sources included a number of scientifically rigorous, behavioural and bio-behavioural surveys, many providing the first HIV prevalence estimates among MSM in the country's major metropolitan areas; vaccine and other clinical trial data; and programme monitoring and evaluation (M&E) data reported to a diverse group of funders including the Global Fund, the US President's Emergency Plan for AIDS Relief (PEPFAR), and private philanthropic foundations. These disparate sources of data had never previously been analysed side-by-side to inform HIV strategic planning, programming, or collaborative research agendas.

In 2013, the University of California San Francisco (UCSF) initiated a national MSM Data Triangulation Project. With financial support from the PEPFAR through the US Centers for Disease Control and Prevention (CDC). UCSF worked with a collaborative group of stakeholders representing South Africa's major community-based and non-government organisations, academic research institutions, civil society organisations, and government agencies to answer the question: ***"To what extent has the national HIV response from 2008-2013 matched the state of the HIV epidemic and HIV-related needs among MSM in South Africa?"***

These partners worked over 14 months from December 2013 through February 2015, to identify, catalogue, and analyse data contributed from all stakeholders, in all 9 provinces, identify trends in the epidemic, gaps in service delivery, and suggest benchmarks for future programme planning.

How to use this Report

This Data Triangulation Report is organized by national and provincial sections. First, data that could be considered nationally representative in some way was analysed and summarized to provide insight into the national picture. Analysis identified trends in the data from which hypotheses about the state of the epidemic and the impact of the national response were developed. We do *not* present these as definitive conclusions. On the contrary, they are at best well-educated guesses on what we know about the epidemic, what may or may not be working in the response, and what remains to be more definitely answered through rigorously conducted research and more comprehensive programming targeting MSM prevention and treatment needs. They should be used as a guide to developing and evaluating national strategic planning, as well as a catalogue of just some of the unanswered questions that require further exploration through further research, and additional programming data.

Data from each of the nine provinces follows the section on national data. These sections will be especially useful to provincial and district-level health officials when they make decisions about where and how to target financial and human resources to improve the quality of healthcare and promote the health of their MSM citizens.

We encourage readers especially to “mind the gaps.” While we were at times surprised by the amount and quality of data from each of the nine provinces, we also noted significant gaps in data that must be filled to fully understand how well South Africa is doing to contain and reverse a concentrated epidemic among MSM that, to date, shows no signs of abating.

A summary of our most critical findings is presented below.

National Picture

HIV: South Africa is experiencing a concentrated HIV epidemic among MSM. There are no indications of stabilization of this epidemic; most indicators suggest a rapidly advancing epidemic, with HIV prevalence estimates between 13-49%, and indications of extraordinarily high incidence.

Other Sexually Transmitted Infections (STI):

- High levels of self-reported STI symptoms, with over one-third of MSM surveyed reporting recent symptoms of a STI.
- Data from 2013 indicates higher levels than data collected earlier in the 2008-2013 period.

Behavioural Risk Factors:

- Inconsistent condom use is very common among MSM, although trends indicate uptake of condom use for anal intercourse with male partners is increasing.
- Use of condom-compatible lubrication has also increased with expanded MSM programme activity in many parts of the country.
- Heavy alcohol use is common among MSM; Illegal substance use, including cannabis (dagga), methamphetamine (tik) and other stimulants are less common, but use of these drugs may be increasing. Many substances are used in the context of sexual encounters, and are likely to increase the frequency of high-risk sexual practices.

Human Rights Violations and Violence:

- Between 10-20% of MSM in Johannesburg (JHB) and Cape Town (CT), and 35% of MSM in (KwaZulu-Natal) (KZN) and Eastern Cape (EC) experienced sexual violence.

Access to Health Care:

- The proportion of MSM who have ever tested and recently tested for HIV has steadily increased. HIV testing at regular intervals, as recommended for MSM, did not appear to be common.
- Condom distribution, including internal condoms, and lubricant distribution to MSM expanded significantly between 2008 and 2013.

Conclusions and Recommendations

While trends of increasing numbers of MSM who have tested for HIV, increased distribution and usage of condoms and lubricants, and increased availability of SI are encouraging signs, we also note several trends in the opposite direction that require immediate attention.

These include but are not limited to:

- Nearly one-third or more of MSM are already infected with HIV.
- MSM are not engaged in HIV care and treatment in proportion to their need in either metropolitan or low-density and rural areas.
- Nationally representative data are few as most research and programme work has targeted larger metropolitan areas.
- Stigma and discrimination, including in health care settings, and violence and other human rights abuses, are common experiences of MSM.
- Heavy alcohol use is very common and frequently linked to sexual HIV risk behaviour between men.

On the basis of existing data, we offer eight specific recommendations:

1. Increase availability, awareness and access to a standard package of MSM-specific HIV prevention tools and services, including condoms and condom-compatible lubricant, STI testing and treatment, MSM-competent HIV counselling and testing, treatment, and PEP.
2. Increase availability, awareness and access to an enhanced package of MSM-specific HIV prevention tools, such as proven biomedical prevention strategies, including PrEP and treatment as prevention (TasP).
3. Increase availability of, awareness of and access to MSM-competent health-care services, including mental health services, and with a specific focus on linkage to and retention in HIV, TB and STI care and treatment.
4. Identify and implement harm reduction approaches for alcohol and other substance use among MSM.
5. Identify underserved areas and subpopulations of MSM not currently reached by MSM programming and address their programming needs, such as MSM in rural areas, MSM who engage in sex work, and MSM under the age of 25 years.
6. Build the capacity of civil society to mobilize MSM for healthy community norms.
7. Address social and structural factors driving the HIV epidemic among MSM, including developing and expanding programmes to mitigate stigma and discrimination owing to homophobia and HIV serostatus.
8. As recommended in the 2012-2016 NSP, implement routine collection and utilisation of SI using standardized measures to identify knowledge and programming gaps across multiple sectors. Funding for surveillance must be sufficient to ensure that nationally representative and generalizable bio-behavioural data are collected at regular intervals (e.g. annually,

biannually). We strongly recommend that bio-behavioural surveillance include HIV incidence, as well as other biological markers, including bacterial and viral STIs. These include syphilis, gonorrhoea, chlamydia, hepatitis B virus (HBV), and hepatitis C virus (HCV). We further recommend initiating and supporting a stakeholder advisory body to facilitate coordination and integration of surveillance with other HIV research priorities.

Data and Service Gaps

Significant data gaps remain to be filled in future HIV surveillance, programmatic research, and M&E work. These gaps include but are not limited to:

- Size estimates of the MSM population, especially in low-density and rural areas
- Nationally representative data on HIV prevalence and incidence
- Linkage and retention in HIV care and treatment
- Knowledge and utilisation of PEP and PrEP
- Drug use and sexual risk behaviour
- MSM-specific data from NDOH High Transmission Area (HTA) programme
- Clinical competency training among policy-makers, managers, and health care providers
- Coverage and uptake of biomedical prevention programming
- Characterization of continuum of care outcomes for MSM
- A nationally representative HIV incidence estimate.

In addition, most provinces currently have no data on interventions in low-density and rural areas, or health service access data. These gaps occur especially in provinces with large rural-based populations, including the EC, Free State (FS), Limpopo (LP), Mpumalanga (MP), North West (NW), and Northern Cape (NC).

We are encouraged that many of the existing data gaps may be filled in 2015. UCSF, Anova Health Institute, and the Human Sciences Research Council (HSRC) are collaborating on HIV surveillance in five provinces, four of them (EC, FS, LP & NW) with low-density and rural MSM communities, which is expected to complete the national picture on HIV prevalence and incidence among MSM. NACOSA and HSRC are implementing a national programmatic mapping and population size estimation project. The HSRC, the Desmond Tutu HIV Foundation, the Johns Hopkins University, and Emory University are collaborating on research that will provide data on combination prevention delivery uptake, including PrEP, as well as research that will evaluate HIV-positive MSM's experiences at each point in the HIV care continuum. PATH is also implementing a national survey on stigma among MSM living with HIV.

With these collaborative programmes, South African stakeholders are on track to make significant strides against the epidemic among MSM, and also in their ability to evaluate the effectiveness of these investments.

Were we to conduct a data triangulation again in 4 or 5 years, we anticipate being able to answer the question of how well the national response has matched the state of the MSM HIV epidemic more affirmatively, and with more complete, nationally representative data that reflects the synergistic effects of these and other efforts.

Forward to 2021

Despite data gaps, this report provides an adequate snapshot of current national and provincial efforts to address the HIV needs of MSM in South Africa, and adequate information to chart a way forward. As this is a synthesis of the vast majority of existing data related to MSM, we trust SANAC and NDOH will find what they need here to conduct a mid-term review of the 2012-2016 NSP, and identify priorities, targets, and funding to implement the next NSP. We hope metropolitan, provincial, and district health officials will find in this report the information they need to work collaboratively with NGOs to ensure that the promise of the Constitution and *batho pele* (people first) principles translate into the perception and reality of equal access to health care of the highest quality for MSM. We encourage researchers and programme implementers, and the funders who support them, to use this report to identify the gaps in knowledge and evidence that will guide their collective efforts to design and implement effective programming that expands access to HIV testing, prevention, and treatment for MSM in South Africa. And finally, we hope other national and key population stakeholders will find here a useful process and method on which to model planning and programming efforts.

1. Background

The legal and policy context for MSM in South Africa

All people have the right to freedom and to realise their potential. South Africa has adopted several international human rights and HIV declarations and commitments that recognise the rights of MSM, their unique vulnerability to HIV and the need for focused interventions. These commitments are reflected in South Africa's legal framework and policies, including the South African Constitution and the *NSP on HIV/AIDS, STIs and TB (2012-2016)*^{1,2}. In 2010, SANAC commissioned a gap analysis that included MSM to inform the development of the NSP. None of the MSM-related targets included in South Africa's NSP on HIV/AIDS (2006-2011) were reached³. Neither did South Africa report to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS indicators relating to the number of MSM reached by HIV prevention programmes and condom use at last sex in the 2012 Global AIDS Response Progress Report⁴. However, since then increased emphasis has been placed on reaching stated commitments. This commitment has been translated into increased collaboration between SANAC, the NDOH and civil society organisations to implement MSM-related policy. In 2012, NDOH developed a draft Framework for HIV, STI and TB Programmes for Key Populations. The NDOH is currently developing a guide to implement this framework, which includes MSM-specific interventions⁵. During 2013 the NDOH also reviewed its guidelines for its High Transmission Area (HTA) Programmeⁱ to increase emphasis on services that are important for HIV prevention, treatment, care and support among MSM, including recommendations relating to MSM peers and increased access to condoms and lubricant⁶.

Social and cultural norms around MSM

South Africa is a largely patriarchal society with heteronormative social norms. Many males in South Africa who have male sexual partners experience stigma and discrimination as a result of socio-cultural norms around masculinity and negative perceptions of sexual partnerships between individuals of the same sex. Same sex practices may be viewed as "un-African"^{7,8}.

However, MSM research and programmes conducted in South Africa between 2008 and 2013 confirm that MSM are an integral part of South African society. MSM exist in all provinces and come from a wide range of socioeconomic and racial backgrounds. For example, a study in 2008 among MSM in Soweto included 99% black MSM, representing all black South African ethnic groups⁹. In another example, a representative study conducted among MSM in CT, Durban and JHB in 2013 included mostly black MSM; 51% of MSM in CT were coloured¹⁰.

Many MSM do not identify with a specific sexual orientation. Furthermore, many MSM also have female sexual partners (MSMW). For example, 20-45% of the men who participated in surveys done among MSM in Soweto, CT and MP between 2008 and 2013 identified as bisexual (i.e. not as gay) and had male and female sexual partners¹⁰⁻¹³.

ⁱ The number of men who have sex with men (MSM) seen at HTA site is now included as a Division of Revenue Act (DORA) indicator.

Developing policy and programmes to be acceptable and appropriate to the range of sexual practices that occur is essential for an effective public health and human rights approach to reduce HIV infections (e.g. messages tailored to the needs of gay-identifying MSM are unlikely to be appropriate to or to reach non-gay identifying MSM)⁷. Social norms and positions that are not supportive of bisexual practices often contribute to internal and external homophobia⁸.

Internalised homophobia refers to negative perceptions and thoughts about one's self for being sexually attracted to a person of the same sex. Internalised homophobia negatively affects mental health, and contributes to substance use and risk taking. Internalised homophobia may also prevent MSM from accessing HIV-related information and services¹⁴. A study in Pretoria identified higher levels of internalised homophobia among MSM from lower socioeconomic circumstances who identified as bisexual. These men had lower levels of understanding regarding HIV and related risks compared to individuals with less internalised homophobia, who identified as gay or homosexual⁸.

External homophobia refers to an irrational aversion to people who are sexually attracted to others of the same sex. This aversion may translate into verbal, emotional and physical abuse, and even murder. High levels of external homophobia have been documented among MSM in a range of contexts and negatively affect their mental, emotional, social and physical well-being. Homophobia also increases their risk of HIV infection directly (e.g. through rape) or indirectly (e.g. stigma and discrimination towards MSM by health care workers when accessing health services)¹⁴⁻¹⁶.

South Africa and the HIV epidemic

South Africa has the largest HIV epidemic in the world¹⁷. In 2014, about one in five adults aged 15-49 years was living with HIV¹⁸. Encouragingly, the number of new HIV infections is decreasing; 469,000 new HIV infections occurred during 2012¹⁹. However, the burden of HIV is disproportionately higher among certain populations, including young women and MSM. Differential vulnerability, exposure and consequences of HIV infection and risk factors that are linked to the social determinants of HIV (including social and cultural norms), high-risk sexual practices and limited access to appropriate, targeted HIV interventions contribute to these concentrated epidemics within South Africa's general epidemic^{3,5,20}.

The HIV epidemic among MSM in South Africa

HIV infections were first recorded in the early 1980s among white MSM in South Africa. This epidemic was essentially separate from the largely black African heterosexual HIV epidemic that followed, as shown by different HIV-1 sub-types identified in these population groups in the late 90s^{ii,21}.

To date neither a national MSM population size estimation nor a large-scale multisite epidemiological study among MSM has been conducted²². As such, no accurate MSM population size estimate exists.

ⁱⁱ In the 1990s subtype B was identified among MSM and subtype C among black heterosexual populations, almost exclusively.

In other contexts, up to 1% of the adult population could be considered as engaging in same sex practices. Making this assumption, in 2014, there would be approximately 1.4 million MSM between the ages of 15 and 49 years old in South Africa¹⁸.

Three percent of men who participated in the 2008 HSRC household survey self-reported same-sex behaviour, and 5.4% of men from the northern part of EC and southern KZN who participated in a different household survey reported ever having had some form of consensual sexual contact with a man^{22,23}.

The 2012 National Household Survey did not sample sufficient MSM to make generalizable estimates¹⁹ and no representative national HIV prevalence or incidence estimates exist²². However, several cross-sectional surveys conducted in various locations across South Africa over several time points indicates MSM to have an HIV prevalence ranging from 10% to 50%, depending on the context^{3,5}.

Existing research has identified structural, social and individual-level risk factors for HIV among MSM²⁴. High levels of institutional discrimination and limited systems for training regarding MSM-related HIV issues are key structural issues. Limited health worker sensitivity regarding MSM issues and limited competency to manage specific sexual health conditions act as barriers to treatment, increasing onward HIV transmission and its consequences^{9,16}. Social exclusion associated with stigma and discrimination directed towards MSM occur and are linked to increased vulnerability to HIV^{15,25}. MSM are often disempowered within social structures, particularly those from lower social classes, which contributes to HIV risk²⁶. On an individual level, limited knowledge about the risks of unprotected anal intercourse and appropriate lubricant use, limited access to condoms and compatible lubricant, high numbers of sexual partners, high levels of unprotected anal intercourse, mental illness and substance use contribute to HIV risk among MSM in South Africa^{11,13,27-29}.

Text box 1 HIV epidemics among MSM in Southern Africa

Policy and social context: Many countries in Southern Africa, including Namibia, Botswana, Zimbabwe and Malawi, have laws that outlaw same-sex practices. Heteronormative and masculine cultural norms further disempower and endanger MSM living in these contexts⁷. Some Southern African countries, such as Swaziland, are making moves to include MSM as part of their national AIDS plans. The WHO recommends MSM-focused services as part of evidence-based, rights-affirming HIV responses^{88,89}.

HIV epidemic and responses: Little data exists on the HIV epidemic among MSM in Southern Africa. However, the few studies that have been completed consistently show higher HIV prevalence among MSM compared to other men. The high HIV burden among MSM in Southern Africa reflects the multiplicative effects of criminalisation of same sex practices, hostile social contexts and limited coverage of HIV-related services for MSM^{90,91,92}.

HIV programming for MSM in South Africa

The civil society sector led policy change and subsequent programming for MSM in South Africa. Civil society organisations in Pretoria and CT have been providing HIV and related services to MSM for over 15 years. Several other organisations have been established across the country and have commenced health service provision, funded largely by bilateral and multilateral donors³.

Gap analyses conducted in 2009, 2011 and 2013 highlighted the need for increased government support and increased coverage of MSM-focused services beyond the three major metropolitan areas^{3,22,30}.

Government funding for MSM has been limited but is increasing, through its High Transmission Areas Programme. However, these programmes are not MSM-specific, and include young women, sex workers and other populations at high risk for HIV infection⁶. Encouragingly, since 2013, the NDOH has made additional commitments to address the needs of MSMⁱⁱⁱ, including:

- Development of an Operational Framework for HIV, STI and TB Programmes for Key Populations in South Africa, that includes MSM
- Increased access to a variety of condoms (different colours, scents, etc.)
- Increased access to condom-compatible lubricant, and
- Sensitisation training regarding issues affecting MSM and other key populations.

SANAC has also increased funding for MSM, including increased MSM-related interventions within financial resources from the Global Fund to Fight AIDS, TB and Malaria. These initiatives will complement investments made by PEPFAR through MSM-focused programmes supported by USAID and CDC. Additional MSM programming is funded by other bilateral donors and development partners, included COC, HIVOS and others.

Reassuringly, MSM-focused programming between 2008 and 2013 increased, largely in relation to increased funding. Specifics are provided in Chapter 5. An assessment of MSM programming conducted in 2013 found that lesbian, gay, bi-sexual, transgender and intersex LGBTI and MSM organisations exist in most major urban areas, with at least one in each province²².

ⁱⁱⁱ By the end of January 2015, the National Department of Health had circulated a tender for the procurement of lubricant and a range of condoms to be available to all people who needed them. 500 health care workers and 72 trainers had been trained from Mpumalanga, Gauteng, the Free State and North West province on the Integrated Sensitisation Training. An implementation guide for the Key Population Operating Framework is being developed.

Text box 2 Young MSM and HIV

International research has highlighted increased HIV risk among adolescent and young MSM. Increased risk is related to limited agency (many live with and are financially dependent on family members who are not supportive of their sexuality). Young MSM who are excluded from their family and social support services are more likely to engage in transactional sex and other high-risk practices (e.g. unprotected sex, substance use) compared to MSM who are included in social support networks. Compared to older MSM, young MSM also have less access to condoms and lubricant, HIV testing and treatment and MSM-focused interventions⁹³.

However despite these risks there is limited epidemiological data about MSM under the age of 18 years in South Africa. Nevertheless, high levels of stigma and discrimination towards MSM among school learners have been identified. School sexual education is almost exclusively heteronormative, and does not include sex education and safer sex messaging that is appropriate for young MSM or other non-gender-conforming individuals^{65,94}.

Few MSM programmes in South Africa provide interventions that address the unique needs of young MSM. A recent situational analysis recommended that future work should include specific interventions for young MSM²².

2. Rationale

To date, behavioural data, sporadic research, and programme information have not been brought together in a systematic, comprehensive way. Thus, the current status and trajectory of the epidemic, the specific drivers of transmission and the impact of the national response on HIV incidence among MSM are uncertain. Reducing these uncertainties through systematic analysis and synthesis of existing data is the context and purpose of the South Africa MSM Data Triangulation Project.

Triangulation is an analytical approach that integrates data from multiple sources to obtain a rational explanation of available data, better understand factors contributing to the HIV epidemic and measure programmatic response to it³¹. Additional detail on the triangulation process is provided later.

Since 2008, significant information about the HIV epidemic among MSM and interventions to respond to it has been generated. A focused review of existing information can inform future responses. The timing of this triangulation process coincides with the SANAC's mid-term review of the implementation of the NSP 2012-2016. In the context of reducing external funding for HIV and the current low levels of domestic economic growth, investing for impact is a major factor to consider in resource allocation for HIV programmatic responses. The triangulation process will assist to identify trends in HIV prevalence, risks and the outcomes of programming between 2008 and 2013. The recommendations from this process could be used to make evidence-informed decisions for the remaining NSP period, and in the development of the NSP 2017-2021 in relation to preventing and treating HIV infections among MSM in South Africa.

3. Limitations

Although triangulation's strength is that it brings all relevant data into consideration, the approach has inherent limitations. The different sources of data carry specific biases and provide different insights into the HIV epidemic among MSM. While triangulation uses multiple data sources to illuminate important aspects of the epidemic and programmatic response, it cannot be used to make conclusions about causality. Although the process inherently seeks to achieve consensus among stakeholders and experts on the most plausible interpretations, we recognize alternative interpretations are possible and uncertainties remain^{31,32}. The following limitations should be noted when reading this report:

Data limitations

- **Our ability to describe definitive trends across data-sets was limited.** Multiple data-sets were collected using different methodologies, population groups, and locations; therefore any trends in the data had to be suggestive and based on broad interpretation rather than on statistical analysis.
- **Access to complete data-sets was limited.** Incomplete information in source documents (e.g. year of data collection) and difficulty accessing unpublished data limited the completeness of the triangulated data.
- **There was sparse data on some key indicators driving the epidemic.** (Refer to Chapter 6 for data gaps.)

Interpretation limitations

- **Multiple factors influence observed trends in MSM programming outputs.** Upward or downward trends (e.g. in condom distribution) may reflect funding realities rather than demand. We note such instances in the report.
- **MSM programming only came on board late in the time period under investigation.** Hence it would be premature to draw conclusions regarding the full impact of the programmatic response.

Process limitations

- **Participation by all stakeholders was voluntary.** Competing priorities of multiple stakeholder agencies challenged many participants' ability to remain fully engaged throughout the period. A more comprehensive activity may have occurred with complete participation by all.

4. Methods

Triangulation refers to the synthesis of data from multiple sources for public health decision-making. Triangulation includes the process of identifying, collecting, arraying together, examining and interpreting data from multiple sources. It has the ultimate purpose of improving our understanding of complex public health problems and our ability to formulate evidence-based decisions to address such problems. Triangulation can be effective when a rigorous, specifically designed research study is not available or when action urgently needs to be taken. Rather than generating new data to answer a specific research hypothesis, triangulation seeks to make the best possible public health decisions based on the available evidence. Triangulation uses inductive reasoning in that it iteratively refines and modifies an explanation of the public health problem based on empirical observations and expert interpretation. Triangulation follows the principles of Second Generation HIV Surveillance by focusing on trends over time and by combining data on the prevalence of HIV and STIs, risk behaviours and programme delivery. Finally, like Second Generation HIV Surveillance, triangulation emphasizes the rapid use of data for public health decision making^{31,32}.

The South Africa MSM Data Triangulation Project was initiated to amass, catalogue, and examine these data together in order to better understand the epidemic, assess prevention programme impact, and facilitate evidence-based decisions on how to address key issues relating to MSM and the HIV epidemic in South Africa.

A 12-step approach to triangulation

1. *Identify key question(s) through stakeholder consensus*
2. *Ensure the questions are answerable and actionable*
3. *Identify data sources and gather background information*
4. *Refine the question(s)*
5. *Gather the data (“data mining”)*
6. *Make observations from each data-set*
7. *Note trends in data and hypothesize on likely explanations*
8. *Refine hypothesis*
9. *If necessary, identify additional data – returning to Step 5*
10. *Summarize findings and conclusions*
11. *Communicate results and make recommendations*
12. *Outline next steps*

Triangulation is an iterative process, gathering and interpreting data in an on-going manner. Nonetheless, the overall approach can be described in 12 sequential steps listed in the box above. These 12 steps approximated the process implemented by the South Africa MSM Data Triangulation Project.

South Africa MSM Data Triangulation Question:

“To what extent has the response from 2008 to 2013 matched the state of the HIV epidemic and HIV-related needs among MSM in South Africa?”

4.1. MSM Data Triangulation Process in South Africa

Triangulation was implemented from September 2013 to February 2015, following the time-frame shown below.

Figure 1 MSM data triangulation time-frame

Activity	Dates	Activities
PLANNING	2013	September <ul style="list-style-type: none"> ● Initial stakeholder consultation in Johannesburg <ul style="list-style-type: none"> ▪ Introduce triangulation concept for South Africa MSM ▪ Brainstorming of organisations and data sources ▪ Planning for the December workshop
		December <ul style="list-style-type: none"> ● Stakeholder workshop in Cape Town <ul style="list-style-type: none"> ▪ Discussion of triangulation process, objectives & timeline ▪ Consensus on main triangulation question & preliminary indicators ▪ Presentation & dissemination of recent MSM clinical and behavioural studies ▪ Formation of triangulation Technical Working Groups (TWG)
DATA MINING	2014	Feb to April <ul style="list-style-type: none"> ● Identification & training of data miners ● Communication with stakeholders to access & send data ● Extensive online search for published & relevant data ● Development of data catalogue & data warehouse with source documents
SYNTHESIS OF DATA		May to September <ul style="list-style-type: none"> ● Data quality assurance checks among catalogued data ● Data extraction from catalogue to data plotting worksheet ● Second round of data mining
		October <ul style="list-style-type: none"> ● Stakeholder working meeting in Johannesburg <ul style="list-style-type: none"> ▪ Presentation and 'best use' of the data plotting worksheet ▪ Stakeholder prioritization of thematic areas and indicators ▪ Formation of provincial working groups & development of preliminary hypothesis
DEVELOPMENT OF REPORT	2015	November 2014 to February 2015 <ul style="list-style-type: none"> ● Development of national report outline ● First (partial) report draft distributed to TWG and partners for preliminary comment ● Stakeholder meeting in Johannesburg <ul style="list-style-type: none"> ▪ Discussion & finalization of provincial hypotheses, narratives, charts, and other report sections ● Core writing group assembled in Johannesburg <ul style="list-style-type: none"> ▪ Finalization of data synthesis & discussion, Executive Summary & recommendation sections of report
DISSEMINATION OF FINDINGS		February <ul style="list-style-type: none"> ● Draft versions of report to TWG and other stakeholders for review and comment ● Begin the dissemination of findings

4.1.1. Planning for triangulation

The triangulation process commenced with a MSM stakeholder consultation in September 2013. Members from the public and private sector attended the half-day meeting in Johannesburg to discuss initial plans to conduct MSM data triangulation in South Africa. After the initial consultation, MSM stakeholders attended a three-day workshop in December in Cape Town. Briefly, the meeting commenced with a presentation describing the steps of data triangulation, and then continued with several presentations from MSM stakeholders who recently conducted or were actively conducting studies in the provinces. Following this, stakeholders discussed and came to consensus on the specific parameters of the activity, including development of the TWG, the main triangulation question and the way forward.

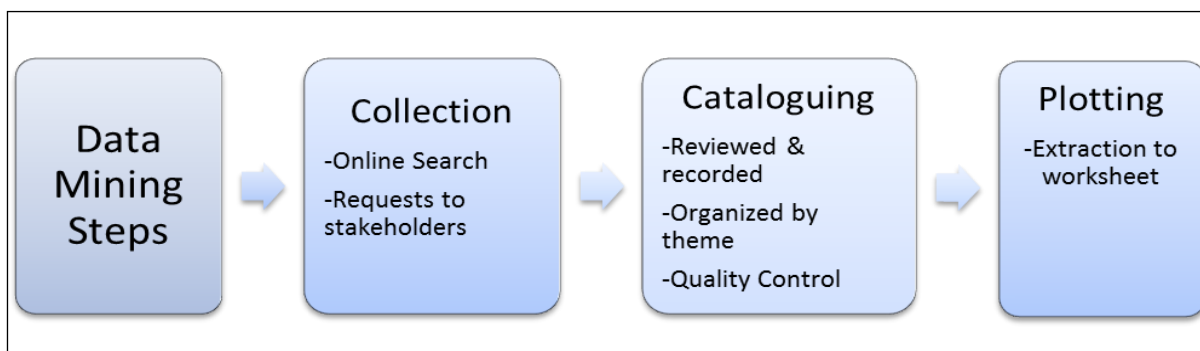
Text box 3 Data Triangulation Technical Working Group

Endorsed by and open to all MSM stakeholders in attendance during the planning meetings, the TWG met regularly during the duration of the triangulation activity. Comprised of members of the public and private sector working with MSM, the main objectives of the group included orchestrating efforts to identify and procure relevant data, providing guidance to ensure all steps of the triangulation process were followed, and troubleshooting problems encountered in the process. To ensure transparency of decision-making, a summary of all nine meetings (in-person and teleconference) were documented and distributed to all members. A copy of the TWG Terms of Reference can be found in the Appendix.

4.1.2. Conducting data mining

February 2014 onward represented the transition from planning triangulation to conducting the activities required. The tasks carried out were done in the spirit of the broad triangulation question, and are best described as an inclusive process, that is, any literature even remotely covering MSM data was collected.

Figure 2 Overview of key triangulation activities



Data miners and other supporting staff were identified and trained on best practices to reach out to stakeholders and request de-identified data, and the systematic process for completing an online search for published peer-reviewed data, presentations and grey literature.

Copies of the original source documents were obtained and filed using a shared network drive. Data miners captured relevant information from each document (author/presenter, type of publication, year and geographical area data was collected, main themes, sample size, author-stated results, and author-stated limitations, as available). This information was documented in a data catalogue. Given the large amount of information mined and later documented, internal quality control measures were taken to verify accurate recording in the catalogue. Data miners met regularly under the UCSF Technical Assistance Team, who then reported back to the TWG on progress, attainment of data saturation and challenges encountered, and to solicit stakeholder feedback. A second round of data triangulation was conducted to capture any recently published data that was consistent with the triangulation question.

Types of Data Collected During Data Mining

Manuscripts Reports Presentations Abstracts Programmatic Training
Materials Dissertations Policies & Guidelines Cost & Finance

From July 2014, an Excel-based data-plotting workbook was developed. Key themes/indicators, driven by prevailing literature and stakeholder recommendation, were the backbone for abstracting relevant quantitative and qualitative information from literature and documenting it within the workbook.

4.1.3. Synthesizing data^{iv}

In October 2014 and again in January 2015, stakeholder working meetings were held. The goal of the workshops was to critically examine and synthesize data and prepare it for inclusion in the planned report. Attendees were presented with the data plotting workbook and they were provided with an explanation of how it was developed and organized (by theme & indicator), for quantitative, qualitative and programmatic data identified during data mining.

^{iv} "Meeting minutes" from stakeholder consultations, synthesis workshops and TWG teleconferences are available upon request.

Text box 4 Prioritizing themes and indicators

With several hundred documents published on MSM research and several data points contained with each document, it became necessary to narrow the scope of the MSM triangulation activity to key themes and indicators, accomplished by way of a stakeholder consensus process.

Through an individual voting process, prioritization of the top 5 indicators and stratifications for the report was completed, along with identifying missing data and developing an action plan to obtain it. Many other themes and indicators were recognized as critical to the MSM epidemic in South Africa but not selected for this current project. They were to be answered at a later time, either through triangulation or another method, as deemed appropriate.

4.1.4. Development of the report

The initial development of the report commenced following the October 2014 stakeholder meeting. As the report grew in content and refinement, drafts were circulated to the TWG and other stakeholders for review and comment. In February 2015, a small group of stakeholders met to finalize the few remaining sections before distributing it to the group for final comment. QGIS 2.4.0-Chugiak with OpenStreetMap was used to develop maps.

4.1.5. Dissemination of findings

The primary deliverable of this triangulation activity is a final report to the government of South Africa to inform policy and programmatic decisions, and to enhance and improve prevention and care and treatment programmes for MSM in the country. Specifically, information contained may be beneficial for the NSP 2012-2016 mid-term review, the development of the MSM-NSP and PEPFAR Country Operational Plan (COP).

5. Findings

This section includes national and provincial level findings^v. Snapshot sections contain summaries of the HIV epidemic, risk factors and programming for MSM. Data sources used for the various graphs are provided^{vi}. Text boxes provide additional information. Data gaps and recommendations are provided elsewhere in the report. A full reference list of cited data sources is provided at the end of this report.

Map 1 Provinces of South Africa



^v The sections on Gauteng, KwaZulu-Natal and the Western Cape are more detailed owing to more information being available for these provinces.

^{vi} Sources in the Snapshot and Hypothesis are referenced using the unique, sequential alphanumeric code generated as part of the data catalogue process. A. Letters identify the type of data source (“J” refers to a published journal article, “P” refers to programmatic data, “R” are reports, “GP” general population data, “CA” conference abstracts and presentations, “CF” costing and financial sources, “PS” position statements and “UP” refers to unpublished data).

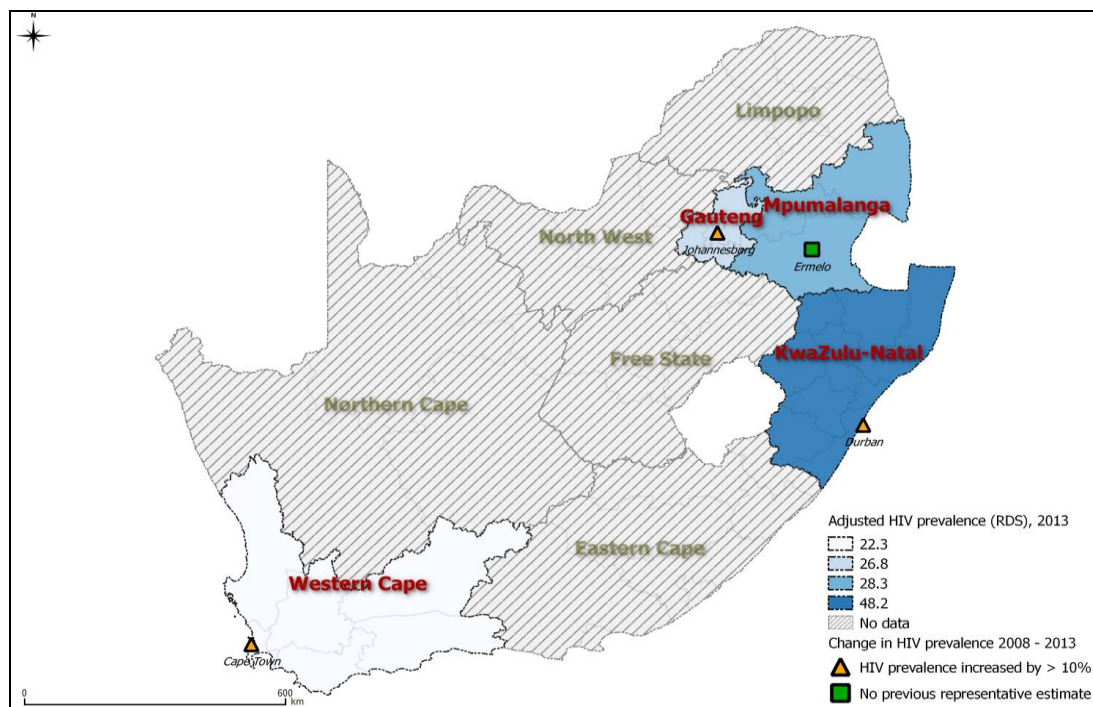
5.1. National picture

5.1.1. Snapshot

HIV epidemic: There is a concentrated HIV epidemic among MSM in South Africa, within the generalised HIV epidemic. There are no indications of stabilization within the MSM epidemic.

- HIV prevalence is between 1.89 and 4.65 times higher among MSM than among non-MSM males of similar ages where representative surveys have been conducted.
- The Ehlanzeni district of Mpumalanga is an exception, where HIV prevalence among MSM is estimated to be the same as for non-MSM (see Figure 3).
- Recent respondent-driven sampling (RDS) surveys show high HIV prevalence among MSM (ranging from 22% in Cape Town to 48% in Durban) (R20)
- HIV prevalence among MSM in Cape Town, Durban and Johannesburg in 2013 is over 10% higher than in 2008 (see Map 2).

Map 2 HIV prevalence trends among MSM, by province, measured by respondent-driven sampling, 2008-2013 (triangles show changes in HIV prevalence since similar 2008 surveys)



Map 2 Sources	
HIV prevalence Western Cape: R20	HIV prevalence Mpumalanga: J38
HIV prevalence Gauteng, Johannesburg: J3, J18, J38, R20	HIV prevalence KwaZulu-Natal: J18, R20

Figure 3 HIV prevalence among MSM, compared to HIV prevalence among males in the general population (aged 15 years and older), 2013

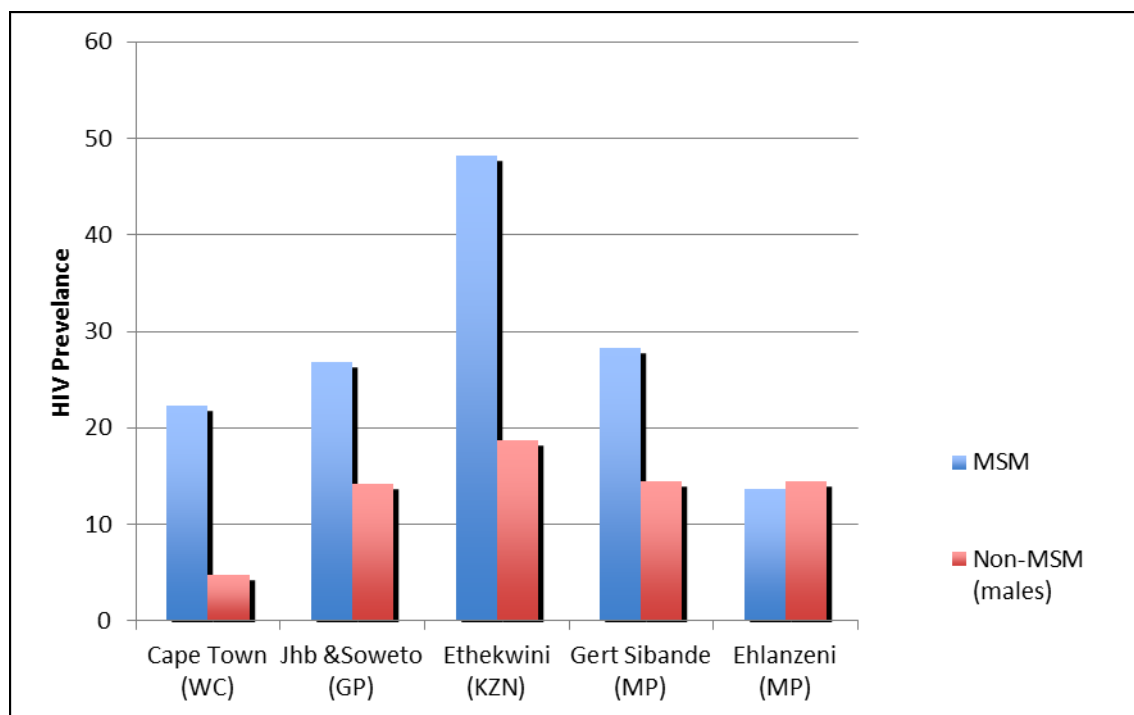


Figure 3 Sources	
MSM HIV prevalence: R20, J38	Non-MSM HIV prevalence: GP02

Prevalence of self-reported STI symptoms: High levels of STIs were documented among MSM during the same period (see *Figure 4*).

- In 2013, over a third of MSM reported recent symptoms of an STI (28.1% in Cape Town, 39.2% in Johannesburg and 42.7% in eThekweni or Durban) (R20).
- Prevalence of recent STIs in 2013 was higher than in previous years (R20).
- STI prevalence is higher among MSM from lower socio-economic contexts (compare, for example, the 12% prevalence of recent STI symptoms among MSM in an internet survey, a 6% prevalence among Western Cape university students, compared to around 30% among MSM from poorer socio-economic backgrounds in peri-urban Cape Town).

Figure 4 Prevalence of STIs among MSM in South Africa, 2008-2013

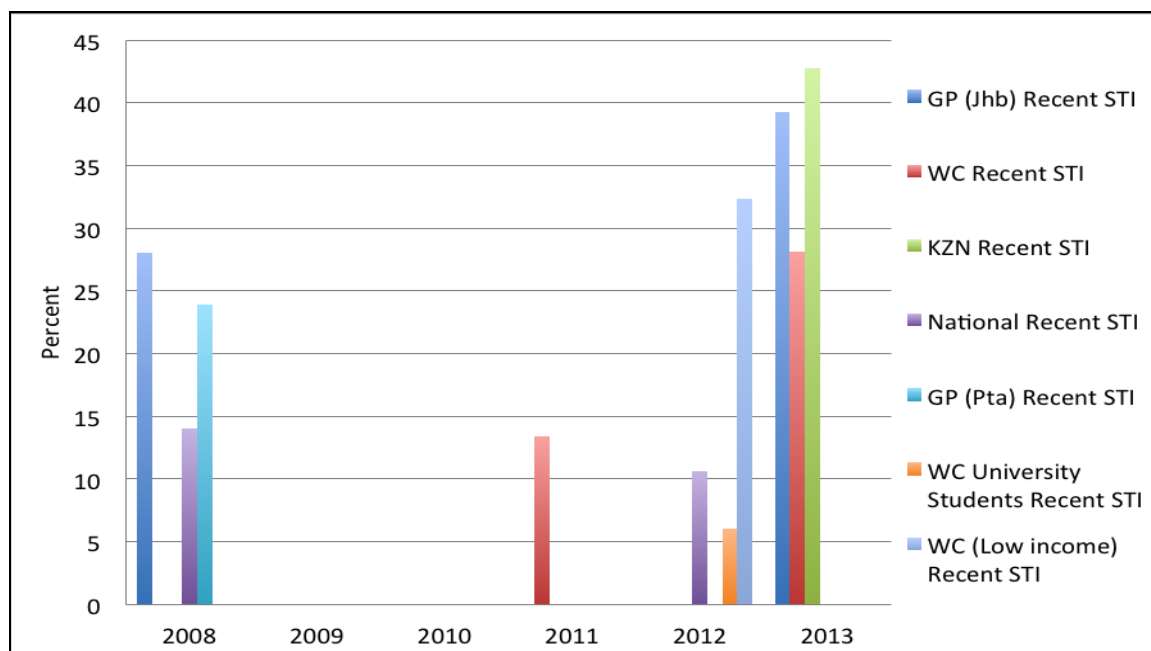


Figure 4 Sources	
National STI, recent: J10, J28	Western Cape (WC) University students, recent: D1
KwaZulu-Natal (KZN) STI, recent: R20	Western Cape (WC), representative, recent: R20
Gauteng (GP) Pretoria (PTA) STI, recent: J8	Western Cape (WC) low income, recent: J27, J20
Gauteng (GP) Johannesburg (JHB), STI, recent: J3, R20	
NOTE: Recent STI refers to within the last 12 months	

Risk factors: High-risk sexual practices are common among MSM.

Risk factors directly associated with HIV infection (e.g. unprotected anal intercourse) appear to be decreasing while several risk factors indirectly associated with HIV infection appear to be increasing (e.g. sexual violence, alcohol use, transactional sex). HIV testing practices among MSM seem to be improving.

- In 2013, about a fifth of MSM reported recent unprotected anal intercourse. However, the prevalence of unprotected anal intercourse appears to have decreased in most locations (see *Figure 5*).
- Use of condom-compatible lubricant appeared to be increasing; similar surveys in Cape Town showed an increase in the use of water-based lubricant from 2% in 2009 to 70% in 2011 (J2) (CA57).
- Most MSM have had sex under the influence of alcohol; in 2012/2013 this ranged from 47% nationally (P10) to 88% in Gauteng (R20) (see *Figure 6*). Illegal substances commonly used by MSM included cannabis, methamphetamine type stimulants (ATS), cocaine and designer drugs (e.g. Ecstasy)³³. In 2012, 31% (n= 40) of MSM participating in an online survey had used ATS in the previous 6 months. Most drugs are smoked or ingested (R1).

- High levels of transactional sex were reported among MSM. In 2013 the prevalence of transactional sex in the previous 6 months ranged from 13% in Ehlanzeni (Mpumalanga) (J38) to 53% in Cape Town (Western Cape) (R20). Transactional sex appeared to have increased in all areas and is more prevalent among MSM from lower socio-economic contexts compared to their more wealthy counterparts (e.g. less than 10% among MSM from urban Cape Town in 2008 and MSM who completed an online survey in 2012) (J33, P10).

Figure 5 Unprotected anal intercourse among MSM in South Africa, 2008-2013

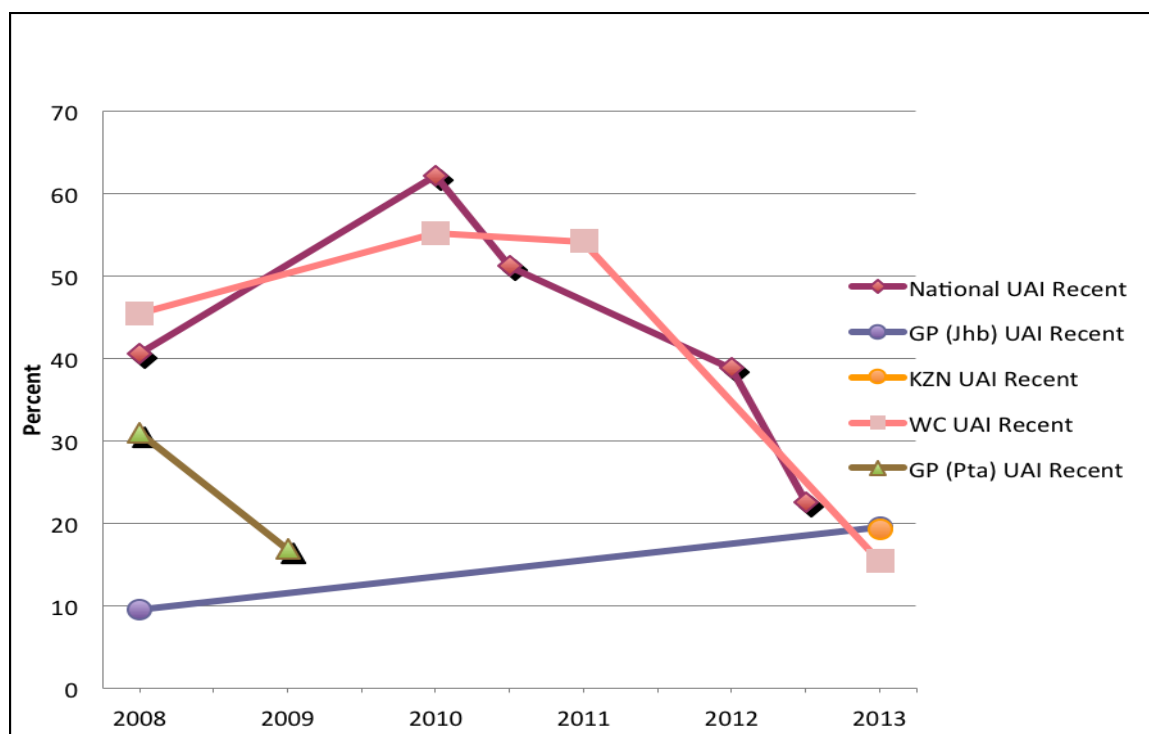


Figure 5 Sources	
National unprotected anal intercourse (UAI), recent: J1, J7, P10, P7-8	Gauteng (GP) Johannesburg (JHB), UAI, recent: J18, R20
KwaZulu-Natal (KZN) UAI recent: J18, R20	Western Cape (WC), recent: J33; UP1, R20
Gauteng (GP) Pretoria (PTA) UAI, recent: J19, J22	NOTE: Recent refers to UAI in the last 12 months

Figure 6 Alcohol use in relation to sexual contacts among MSM in South Africa, 2008-2013

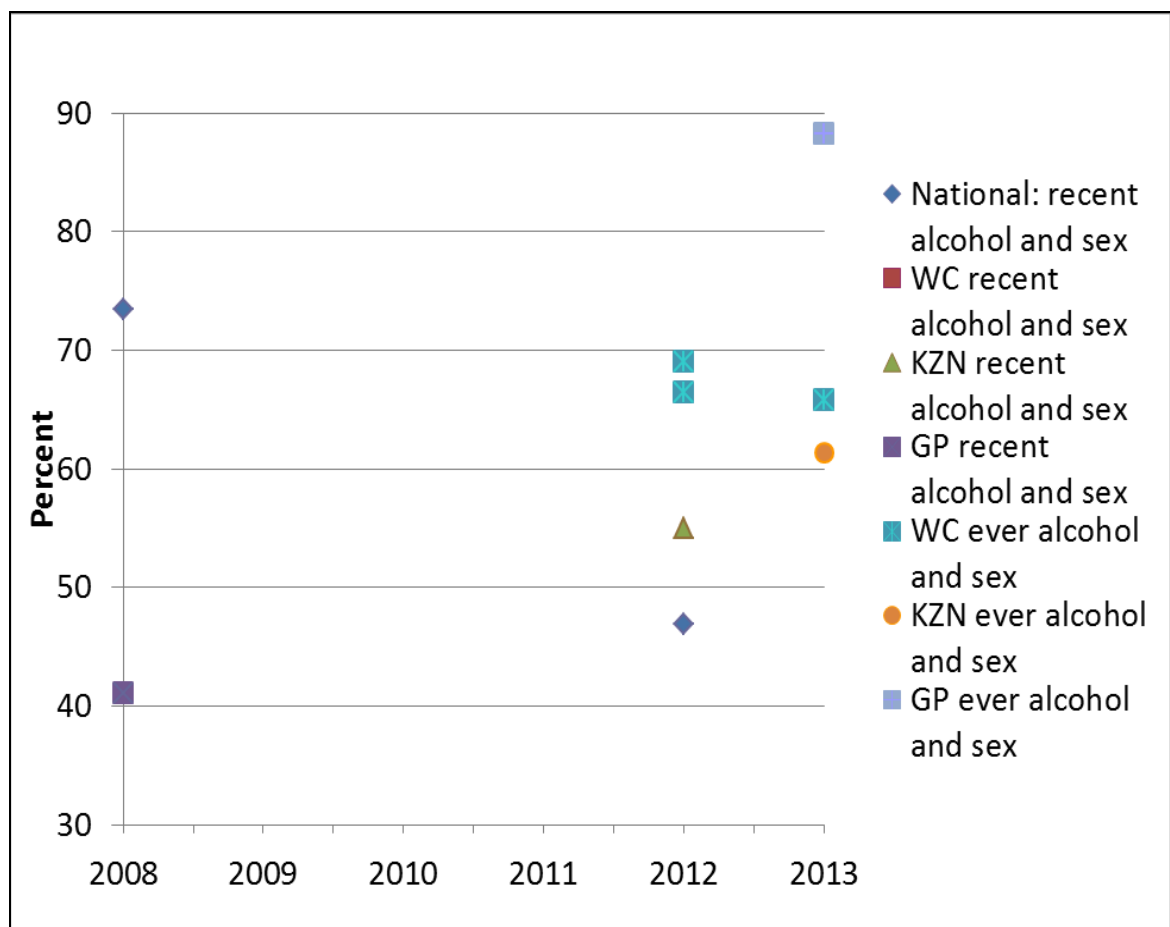


Figure 6 Sources	
National unprotected anal intercourse (UAI), recent: J1, J7, P10, P7-8	Gauteng (GP) Johannesburg (JHB), UAI, recent: J18, R20
KwaZulu-Natal (KZN) UAI recent: J18, R20	Western Cape (WC), recent: J33; UP1, R20
Gauteng (GP) Pretoria (PTA) UAI, recent: J19, J22	
NOTE: Recent refers to UAI in the last 12 months	

Human rights violations:

- Sexual violence commonly affects MSM.** In 2008, 35% of MSM from KwaZulu-Natal and the Eastern Cape who took part in a household survey had experienced sexual violence (J4). The prevalence of reported sexual violence appears to be increasing (see *Figure 7*).

Figure 7 Sexual violence among MSM in South Africa, 2008-2013

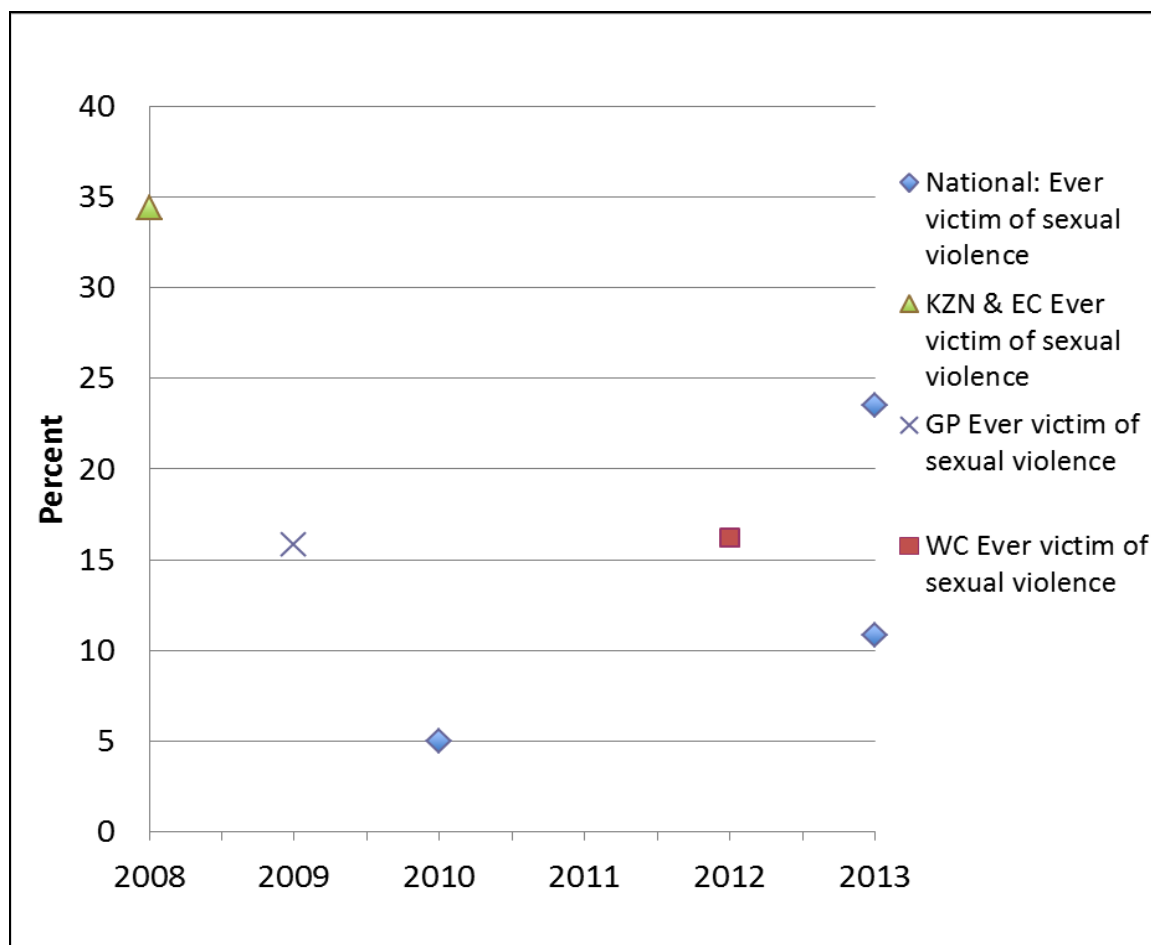


Figure 7 Sources	
National data on victim of sexual violence: J1, J49, R18	KwaZulu-Natal (KZN) and Eastern Cape (EC) victim of sexual violence: J4
Western Cape (WC) victim of sexual violence: J2, J20	Gauteng (GP) victim of sexual violence: J22

Access to health care:

- HIV testing among MSM is increasing.** In 2013 just under two thirds of MSM reported having tested for HIV in the previous 12 months in the three largest metropolitan areas (61%, 72% and 73% in Johannesburg, Cape Town and Durban, respectively). Reported HIV testing practices from the latest data are provided in *Figure 8*. Trends in reported HIV testing (recent and ever tested) by location (city) and where possible by sub-group is provided in *Figure 9*. *Figure 9* shows how little data on HIV testing practices among MSM existed around 2008 and 2011. More studies collecting data on MSM testing were collected in 2012 and 2013 from Gauteng, KwaZulu-Natal and the Western Cape. Encouraging, reported HIV testing among MSM across the country had increased.

Figure 8 HIV testing practices among MSM in South Africa by province, most recent data

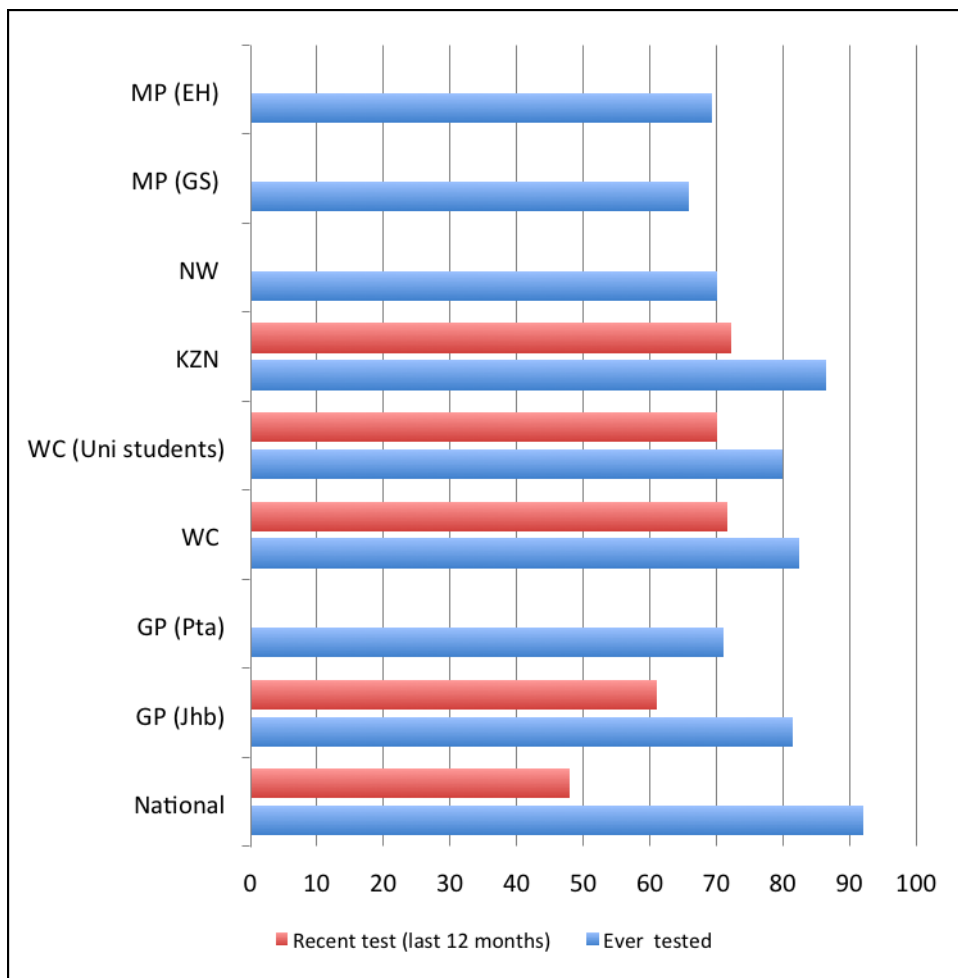


Figure 8 Sources	
National: J28, P10	Western Cape (WC): R20, D1
KwaZulu-Natal (KZN): R20	Mpumalanga (MP) Gert Sibande (GS): J38
Gauteng (GP) Pretoria (PTA): J14	Mpumalanga (MP) Ehlanzeni (EH): J38
Gauteng (GP) Johannesburg (JHB): R20	North West (NW): R8

Figure 9 HIV testing practices among MSM in South Africa, 2008-2013

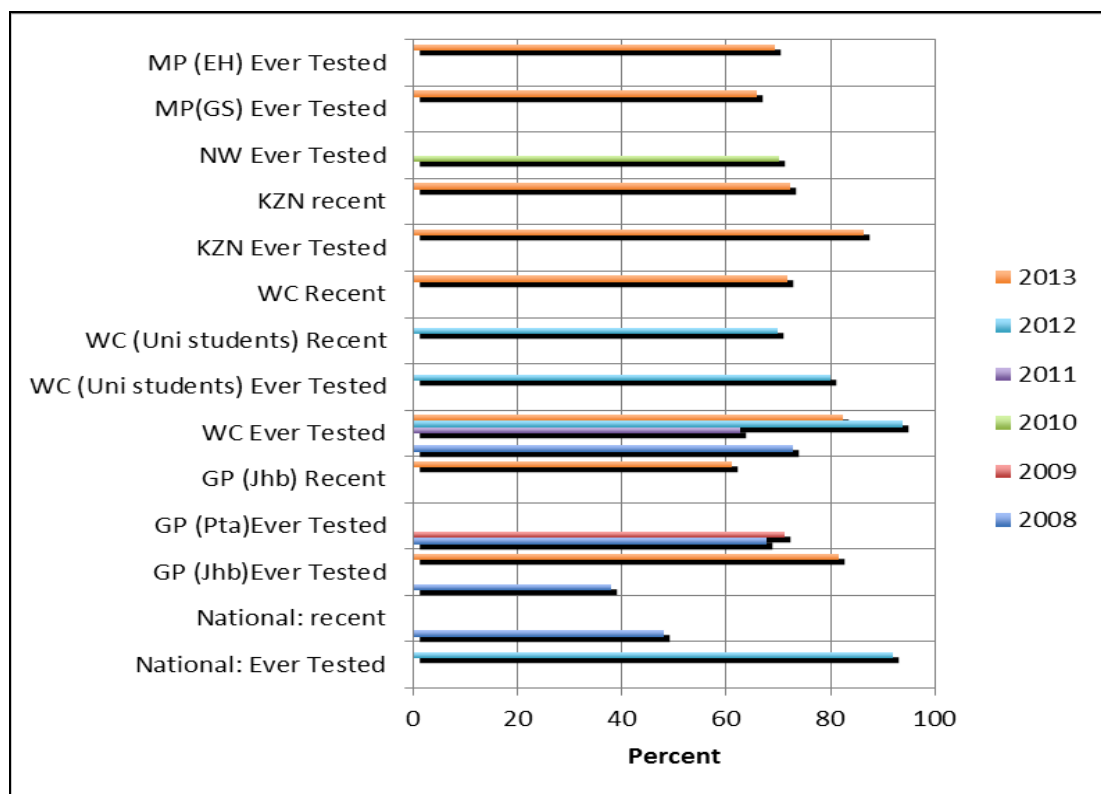


Figure 9 Sources	
National ever: P10	Western Cape (WC) ever: J33, J20, J27, R20
National recent: J28	Western Cape (WC) recent: R20
KwaZulu-Natal (KZN) ever: R20	Western Cape (WC) University (Uni) students: D1
KwaZulu-Natal (KZN) recent: R20	Mpumalanga (MP) Gert Sibande (GS): J38
Gauteng (GP) Pretoria (PTA) ever: J8, J14	Mpumalanga (MP) Ehlanzeni (EH): J38
Gauteng (GP) Johannesburg (JHB) ever: J3, R20	North West (NW): R8
Gauteng (GP) Johannesburg (JHB) recent: R20	NOTE: Recent refers to testing in the last 12 months

Programming: Provision of MSM-focused services and distribution of HIV prevention commodities dramatically increased between 2008 and 2013 (see *Figure 10*).

- The number of MSM accessing HIV testing increased from 628 in 2008 to 8,801 in 2013.
- The number of external (male) condoms distributed increased from 16,678 units in 2008 to over 3.1 million in 2013.
- The number of internal (female) condoms distributed increased from 1,967 units in 2012 to 22,000 units in 2013.
- The number of lubricant sachets distributed increased from 16,678 in 2008 to 629,426 units in 2013.
- The number of MSM reached by small group interventions increased from 2,849 in 2012 to 19,023 in 2013.

Figure 10 MSM programming in South Africa, 2008-2013

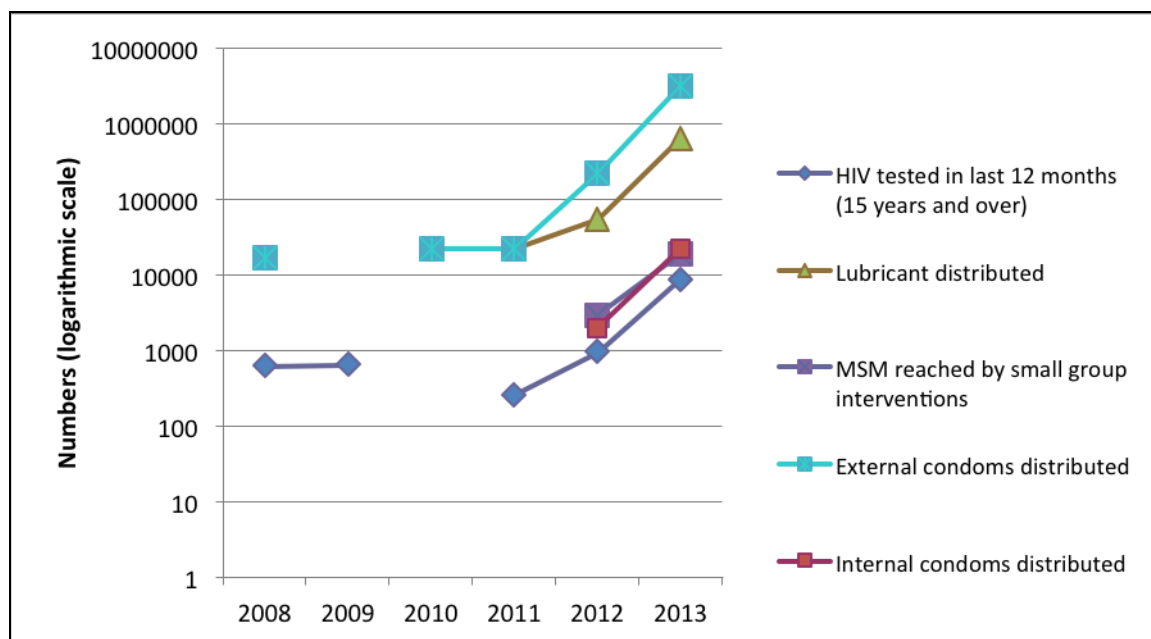


Figure 10 Sources
Programmatic data: R24, R25, R26, P5, P6, P11, P12
Note: Breaks in trend lines reflect data reflect data that was not available, missing or where services had not been commenced

5.1.2. Hypothesis

- Increasing HIV prevalence reflects increased detection of prevalent HIV infections among MSM.
- Increasing HIV prevalence reflects a reduction in HIV-related deaths.
- Increasing HIV prevalence is owing to new HIV infections, which are due to:
 - (1) on-going high risk practices (UAI, alcohol use and transactional sex)
 - (2) high levels of violence affecting MSM, including sexual violence
 - (3) socio-economic factors (exclusion, poverty, unemployment, etc.)
 - (4) structural factors (insufficient coverage, saturation of services, etc.), and
 - (5) on-going stigma and discrimination.
- High levels of HIV testing in WC, KZN and GP are due to MSM-focused programmes in those provinces.
- Cultural norms and values that stigmatise and discriminate against MSM are limiting the effectiveness of current interventions.
- Low levels of HIV testing among rural MSM suggests lower penetration of MSM-focused HIV campaigns in rural areas.

Text box 5 Planned strategic information and research activities for MSM in South Africa (2014-2016)

- The NDOH-revised HTA guidelines include recommendations for data to be categorised by population group, including MSM.
- In 2014, the Desmond Tutu HIV Foundation, the HSRC, the Johns Hopkins Bloomberg School of Public Health, US NIH, the South African NHLS, University of California Los Angeles School of Public Health, Emory Rollins School of Public Health and CDC commenced The Sibanye Project, that will assess the acceptability and feasibility of providing a package of HIV prevention and treatment services, including PrEP, to 200 MSM (100 in Cape Town and 100 in Port Elizabeth) for 1 year.
- In 2015, SANAC is planning to conduct a nationwide programmatic mapping exercise of key populations (KPs), including MSM, that will include identification of locations where KPs congregate and provide a national size estimate.
- In 2015, UCSF, with funding from PEPFAR/CDC, will conduct an integrated bio-behavioural survey among MSM in five large urban areas where data does not exist.
- In 2015, the HSRC, in partnership with other organisations, will implement a Key Population Implementation Science project across six provinces and multiple sites to investigate the effectiveness of a package of innovative interventions to reach MSM and link them to health services, improve programme delivery and uptake of services, retain MSM living with HIV in care, and support adherence to antiretroviral therapy (ART) to achieve viral suppression.
- In 2015, the Anova Health Institute, with funding from USAID, EJAF and the Global Fund, will expand MSM service delivery nationally and will increase prevention efforts through a communication campaign. Through these efforts strategic information will be gathered in formal settings such as clinics, informal settings such as shebeens and through the social media.
- Anova is also proposing a PrEP demonstration project to run in Johannesburg and Cape Town.
- A national survey of stigma experienced by MSM living with HIV is planned by PATH in 2015 with funding from USAID and MAC AIDS.
- In 2014-2015, UCSF and Anova Health Institute will conduct a follow-up RDS survey in the Gert Sibande and Ehlanzeni Districts of Mpumalanga.
- UCSF in collaboration with the Anova Health Institute launched Project Boithato in 2013, an HIV prevention intervention aimed at increasing consistent condom use, regular HIV testing for HIV-negative MSM and linkage to care for HIV-positive MSM. An evaluation of this intervention will be completed sometime in 2015.

National Reference List					
CatID	Author	Year	n Size	Method	Location
J3	Lane et al. 2009 ²⁸	2008	378 MSM	RDS	Soweto, Gauteng
J38	Lane et al. ¹¹	2013	307 MSM in Gert Sibande, 298 MSM in Ehlanzeni	RDS	Ehlanzeni and Gert Sibande Districts, Mpumalanga
R20	Cloete et al. ¹⁰	2013	286 MSM in CT; 290 MSM in Durban, 349 MSM in JNB	RDS	Cape Town, Durban and Johannesburg
J18	Rispel et al. ²⁹	2008	81 MSM in DBN, 204 MSM in JNB	RDS	Durban and Johannesburg
R8	Baird et al. ³⁴	2010	169 MSM	Convenience	Several cities in NW
J14	Tun et al. ⁸	2009	307 MSM	RDS	Pretoria
P10	Anova Health Institute ³⁵	2012	820 MSM	Online, convenience	Across South Africa
D1	Brink et al. ³⁶	2012	50 MSM	Convenience	Stellenbosch University, WC
J19	Sandfort et al. ³⁷	2008	300 MSM	RDS	Pretoria
UP1	Brown et al. ³⁸	2011	330 MSM	Convenience	Cape Town (urban centre)
J1	Stephenson et al. ³⁹	2010	521 MSM	Online, convenience	Across South Africa
J7	Wagenaar et al. ⁴⁰	2010	338 MSM	Online, convenience	Across South Africa
J22	Vu et al. ⁴¹	2009	307 MSM	RDS	Pretoria
J33	Burrell et al. ¹³	2008	542 MSM	Convenience	Cape Town (urban centre)
J24	Tucker et al. ¹⁵	2010	169 MSM	Convenience	Cape Town (peri-urban)
J27	Batist et al. ⁴²	2012	98 MSM	Convenience	Cape Town (peri-urban)
J20	Eaton et al. ⁴³	2011	143 MSMW	Convenience	Cape Town (peri-urban)
J8	Knox et al. ⁴⁴	2008	300 MSM	Multiple	Pretoria
P7-8	Global Forum of MSM and HIV ⁴⁵	2012	137 MSM	Online, convenience	Across South Africa
GP02	HSRC ⁴⁶	2012	N/A	HH survey – additional analysis	National
P5	Anova/Health4Men	Multiple	N/A	Programme data	Gauteng and Western Cape
P6	Anova/Health4Men	Multiple	N/A	Programme data	Gauteng and Western Cape
P11	ICAP KP Data ⁴⁷	2012-13	N/A	Programme data	Gauteng,

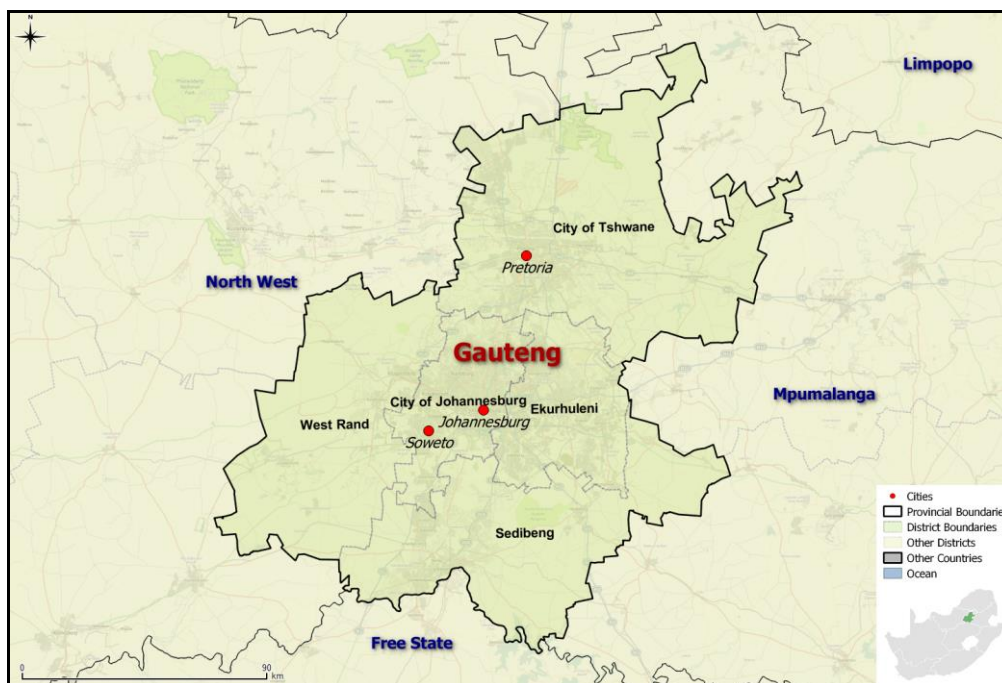
5.2. Gauteng

5.2.1. Snapshot

Background: Geographically, Gauteng is the smallest of the nine provinces, but also the most populous, with nearly 12.3 million people. Johannesburg represents the largest city (in the province and nationally), while Pretoria serves as the province's administrative hub. The largest racial groups are black Africans (77%) and whites (15.6%). Approximately 40% of the residents have completed high school¹⁸. The median age is 27 years, with the median annual income of working adults being R23,539 (\$2,000 USD). About 1 in 4 adults are unemployed. The first-ever South African Gay Pride event was held in 1990 in Johannesburg. Other Gauteng pride events have taken place in Soweto, Ekurhuleni, Pretoria, and Mamelodi.

Ideally, consideration should be given to both the Johannesburg Metro and the greater Pretoria/Tshwane Metro located approximately 70 km away. However, given the lack of prevalence data from Pretoria, figures for the geographic regions have been combined.

Map 3 Map of Gauteng



HIV epidemic: Overall, the HIV prevalence among MSM in Gauteng's largest cities appeared to be unchanged during this period.

- In 2013, the HIV prevalence among MSM in Johannesburg was estimated at 26.8% (R20), which is 1.89 times higher than the HIV prevalence among adults aged 15-49 years in Gauteng province (GP02).
- In 2012, the HIV prevalence among MSM in Pretoria was estimated at 30.1% (CA21).
- In 2008, an imputed point estimate of 13.2% was observed among a largely heterosexual or bisexual-identified population in Johannesburg/Soweto (J3); the rate was 33.9% among

gay-identified men (not shown). This compares with another 2008 Johannesburg estimate of 49.5% (J18).

Figure 11 HIV prevalence among MSM in Gauteng, 2008-2013

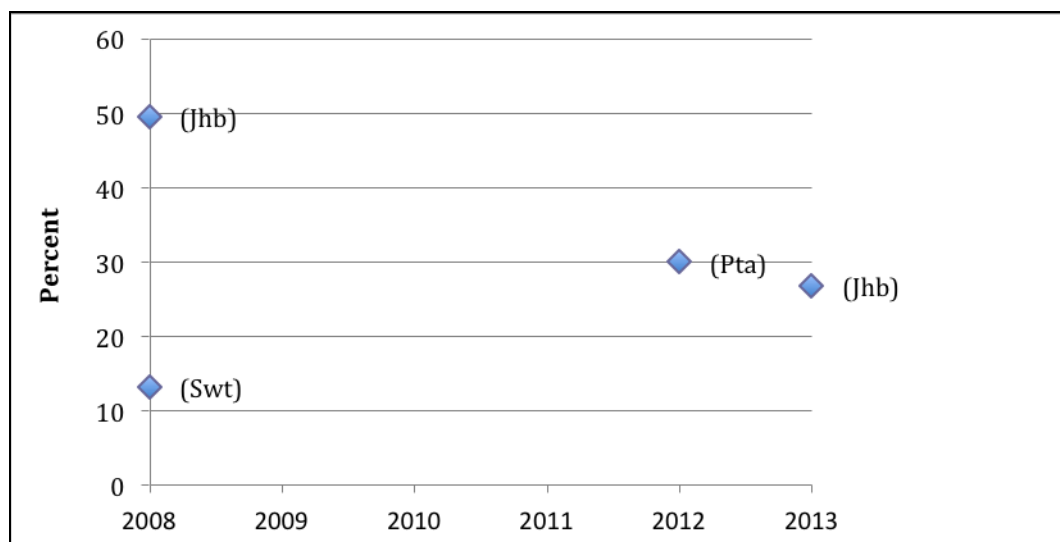


Figure 11 Sources	
Gauteng (GP) Johannesburg: R20,J18	Gauteng (GP) Pretoria: CA21
Gauteng (GP) Soweto: J3	

Prevalence of self-reported STI symptoms: The presence of some STIs may be a marker for high-risk sexual behaviour and subsequent risk for HIV transmission. Although limited clinical data was available for Gauteng, several studies exist of collected self-reported STI information among MSM. Despite the potential for social desirability bias and subsequent underreporting of this outcome, nearly a quarter to more than a third of men reported such an infection in the previous 12 months.

- In a 2013 RDS survey, more than one in three MSM in Johannesburg (39.2%) reported an STI symptom in the previous 12 months (R20). This compares with a lower RDS estimate of one in four MSM in Soweto (28.0%) in 2008 (J3).
- A point estimate of 23.9% MSM from a community survey in Pretoria during 2008 reported an STI (J8).

Risk factors: Alcohol use associated with sex, multiple recent sex partners and transactional sex are among the risk factors affecting MSM in Gauteng (see *Figure 12*).

- MSM are engaging in UAI (J19, J22) and more than half of MSM (55.6%) had three or more male sexual partners in the previous six months (R20). Additionally, 23.0% of MSM also reported engaging in vaginal sex during the same recall period (not shown).

- Transactional sex (receiving money or goods), both in terms ever or recently engaging in it, remained prevalent throughout 2008 and 2013 (J3, J14, R20,CA20).
- Alcohol use around sexual encounters remained high across data points (J19, R20).

Figure 12 Risk behaviours among MSM in Gauteng

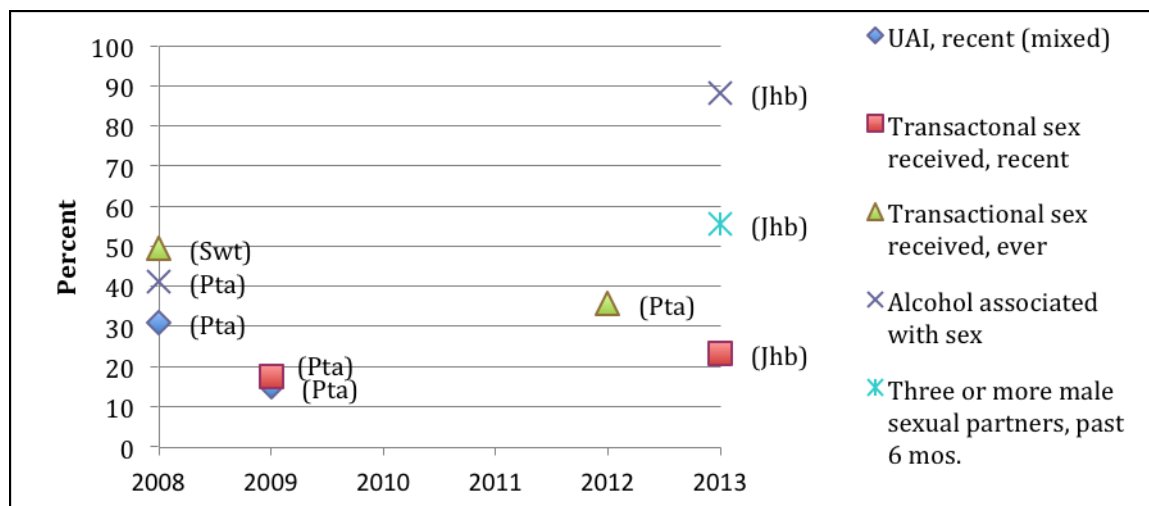


Figure 12 Sources	
UAI: J19, J22	Transactional Sex: J3, J14, R20, CA20
Multiple Partners: R20	Alcohol and Sex: J19, R20
Note: Recent transactional sex received refers to having received money, gifts or shelter in exchange for sex in last 6 months. UAI-recent varied by study; at last sex or during previous two months.	

Human rights violations: Consistent with national findings, the prevalence of sexual violence and discrimination against MSM has been observed. These actions can directly and indirectly pose a barrier to men seeking health services and being open about their sexual orientation to providers and others.

- More than half of a representative sample in Pretoria had verbal insults directed at them for being gay (J22), while discrimination by police owing to their sexual orientation was reported by more than one in five MSM (R20).
- 15.8% of MSM were victims of forced sex in the previous 12 months (J22).

Access to health care:

- MSM accessed HIV testing at gay-friendly clinics more so than at public hospitals (39.9% versus 26.2%) (R20).
- MSM reporting ever having tested for HIV increased between 2008, 2009 and 2013: 67.7% (J8), 71.1% (J28), and 81.5% (R20), respectively.

Programming: The period 2008-2013 can be described as a period that saw the expansion of HIV prevention programming for MSM. Particularly in the later years, large numbers of condom and lube sachets were distributed alongside an uptake in behavioural change interventions, although still reaching only a small number of MSM overall. At the same time, HIV testing and HIV positive test results increased in parallel.

Figure 13 MSM programming in Gauteng, 2008-2013

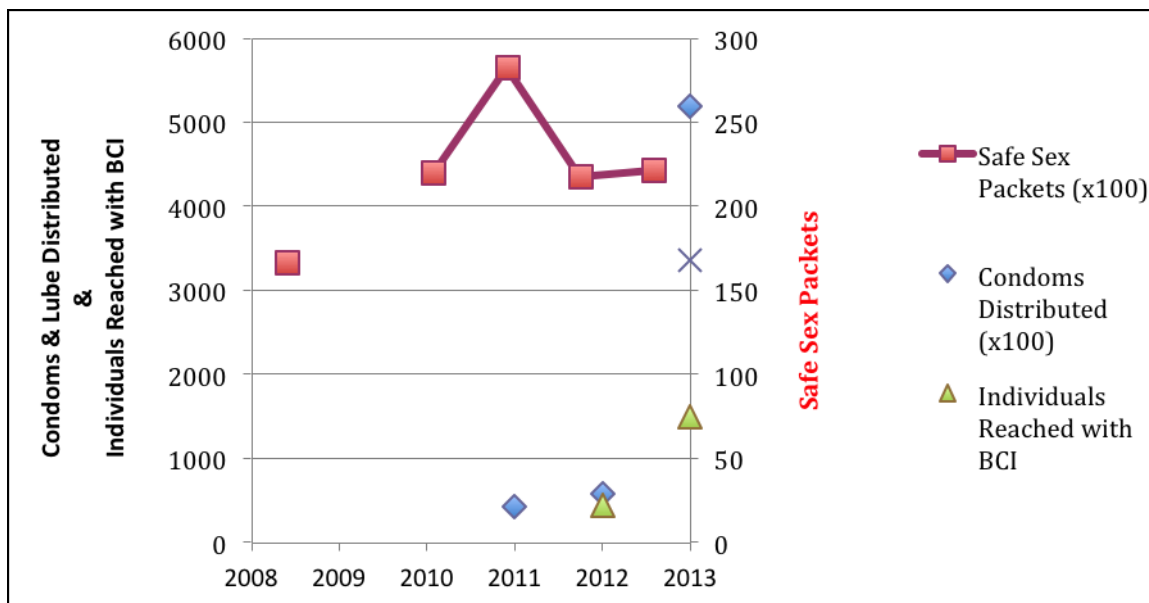


Figure 13 Sources	
Gauteng: R25, R26, P6	NOTE: Behaviour change interventions (BCI)

- Across three organisations serving MSM, over 3,000 HIV tests were administered in 2013 (R24, P11, P5), compared to less than 500 in 2012, based on available data for that year.
- Although precise comparisons across years were difficult to make owing to the large differences in the number of individuals tested and the way in which data was collected, it appears that a larger proportion tested HIV positive in 2013 compared to 2012 (R24, P11, P5).

5.2.2. Hypothesis

- It is too early to make a complete assessment of the programmatic response to the HIV epidemic in Gauteng.
- Programming appears to have led to increased numbers of MSM testing and increased distribution of condoms and lube.
- The increase in the proportion of MSM who tested positive was, in part, associated with an uptake in MSM getting tested for HIV.

Gauteng Reference List					
CatID	Author	Year	n Size	Method	Location
R20	Cloete, et al. ¹⁰	2013	349/Jhb	RDS	Johannesburg
CA21	Sandfort, et al. ⁴⁸	2012	480	RDS	Pretoria/Tshwane
J3	Lane, et al. ²⁸	2008	378	RDS	Soweto
J18	Rispel, et al. ²⁹	2008	204/Jhb	RDS	Johannesburg
J8	Knox, et al. ⁴⁴	2008	300	Multiple	Pretoria
J19	Sandfort, et al. ³⁷	2008	300	Multiple	Pretoria
J22	Vu, et al. ⁸	2009	324	RDS	Pretoria
J14	Tun, et al. Tun ⁴⁹	2009	324	RDS	Pretoria
GP02	HSRC ⁴⁶	2012	N/A	HH Survey	National
CA20	Masvawure, et al. ⁵⁰	2012	81	Multiple	Pretoria/Tshwane
R24	OUT Annual Report ⁵¹	2012-13	N/A	N/A	Gauteng
R25	OUT Annual Report ⁵²	2011-12	N/A	N/A	Gauteng
R26	OUT Annual Report ⁵³	2010-11	N/A	N/A	Gauteng
P5	Anova/Health4Men ⁵⁴	Multiple	N/A	Programme Data	Gauteng
P6	Anova/Health4Men ⁵⁵	Multiple	N/A	Programme Data	Gauteng
P11	ICAP KP Data ⁴⁷	2012-13	N/A	Programme Data	Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo and Northern Cape

5.3. Western Cape

5.3.1. Snapshot

Background: The Western Cape is situated in the south-western part of South Africa. Approximately 6.1 million people (11.3% of the South African population) live in this province. Life expectancy for males in the Western Cape is the highest in the country (63.7 years for 2011-2016). The Western Cape has the second highest (after Gauteng) net inwards migration of people (153, 611 people between 2006 and 2011)¹⁸.

Cape Town is the provincial capital and the country's second largest metropolitan area (3.7 million people in 2011). In 2011, two thirds of the population of the Western Cape were between 15 and 64 years of age. About a third of people have secondary education (29.8%) and about a quarter of people are unemployed (23.9%)⁵⁶.

Map 4 Map of the Western Cape



Cape Town has a visible concentration of gay-focused venues within the city centre. However, this leisure space was influenced by apartheid legacy and largely caters to wealthy white men⁵⁷. Although Cape Town remains largely racially and economically segregated, sexual relationships between MSM of different racial groups, including black African and white males, are evidenced by the recombinant HIV subtypes prevalence within HIV infection of MSM in Cape Town²¹. Gay-friendly leisure spaces and venues exist in peri-urban Cape Town and are being increasingly used to access MSM community members^{15,22}. Homophobia and stigma commonly affect MSM in peri-urban Cape Town, contributing to high levels of depression and high-risk practices among them⁵⁸.

Most people live in formal dwellings (78.4%). However, lower-economic, informal settlements are found in the peri-urban areas surrounding central Cape Town.

HIV prevalence and the risk of HIV infection are higher among MSM, and access to HIV services is more limited in peri-urban areas as compared to central Cape Town^{26,59}.

Since the late 1990s civil society organisations have provided the bulk of MSM-focused services. Recently MSM-focused specialized clinics, safe spaces and services have been scaled up. Grassroots MSM organisations have been established in the greater Cape Town area and in some areas of the West Coast and Winelands regions.

HIV epidemic: Overall HIV prevalence increased over time with significant fluctuations (see *Figure 14*).

- In 2013, the HIV prevalence among MSM in Cape Town was estimated at 22.3% (R20), which is 4.65 times higher than the HIV prevalence among males aged between 15 and 49 years in the Western Cape (GP01).
- HIV prevalence increased at a comparatively higher rate among MSM in peri-urban areas compared to their counterparts in urban areas of Cape Town.
- Lower HIV prevalence data points have been found among MSM who also have female sexual partners.

Figure 14 HIV prevalence among MSM in Cape Town 2008-2013

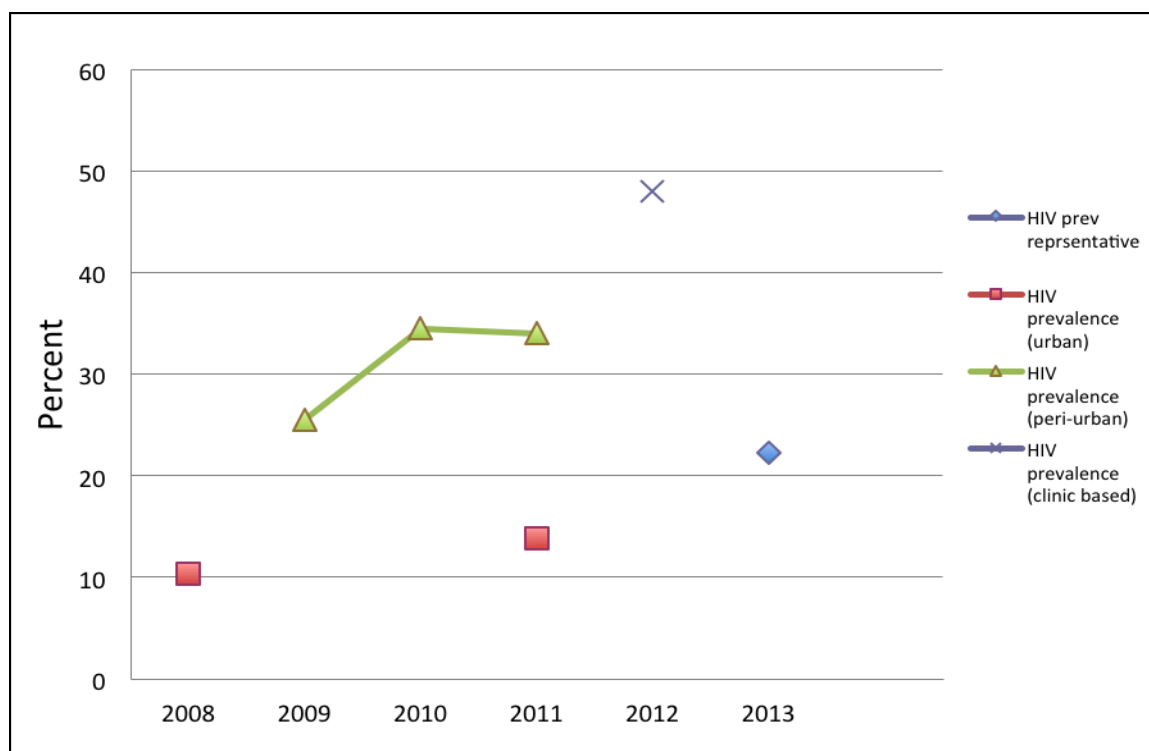


Figure 14 Sources	
Western Cape (WC), Cape Town: R20	Western Cape (WC) Cape Town peri-urban: J33, J23, UP1
Western Cape (WC) Cape Town urban: J2, UP1	Western Cape (WC) clinic based: UP2

Prevalence of self-reported STI symptoms: In 2013, under a third (28.1%) of MSM reported a STI in the previous 12 months (R20).

Risk factors: Generally speaking, HIV risk practices among MSM in Cape Town appeared to be increasing (see *Figure 15*).

- Recent (last 6 months) unprotected anal intercourse (UAI) remained high (J24, UP1).
- The use of water-based lubricant increased (J2, CA57).
- Recent studies suggested transactional sex (received) remained prevalent in the community (18% in 2011 compared to 52.6% in 2013) (J20, R20).
- Alcohol use in the context of sex was high within this population. In 2013, two thirds of MSM in Cape Town were estimated to have reported alcohol around the time of sex (R20).
- Use of PEP remains very low. In a 2011 survey, less than 6% of MSM had accessed PEP (5.7%) from the Cape Town centre (actual figure 5.7%), and about half that proportion among MSM in peri-urban areas (3%) (CA57).

Figure 15 HIV-related risk factors among MSM in Cape Town, 2008-2013

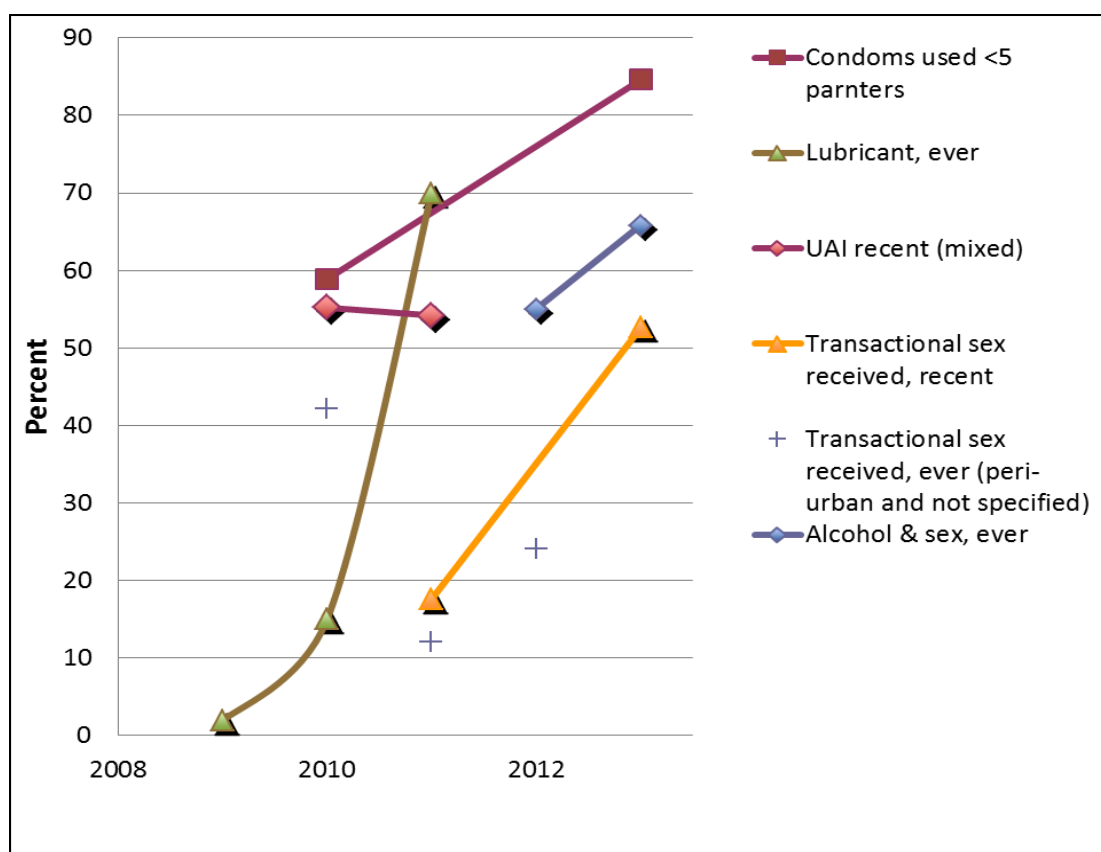


Figure 15 Sources	
Alcohol and sex: D1, UP1, UP2, R20,	Water-based lubricant use: J2; CA57
Transactional sex, received: J20,R20,J2,J27,UP1	UAI: J24, UP1
Condom use: UP1, R20	
Note: Recent transactional sex received refers to having received money, gifts or shelter in exchange for sex in last 6 months	

Human rights violations: Approximately 1 in 4 peri-urban MSM reported being a victim of at least one human rights violation, including being denied health care or housing, or being beaten by police or a government official owing to their sexual orientation (J2).

Access to health care: More MSM accessed HIV testing at gay-friendly clinics compared to public hospitals (29.0% versus 21.6%) (R20). Earlier studies conducted among MSM in Cape Town highlighted that many MSM did not access public health services owing to stigma and discrimination (J2).

Programming: The amount of condoms and lubricant reported to have been distributed decreased in the Cape Town area, directly linked to funding. Programmatic data comes from Anova Health Institute's Health4Men Programme. Due to the absence of MSM population size estimates for the province, the proportion of MSM receiving services is not known (P6). In 2013:

- 4,252 MSM were reached with behaviour change interventions
- 2,780 MSM were tested for HIV and provided with their test results
- 120,000 condoms and 20,000 units of lubricant were distributed (P6) (see *Figure 16*).

Triangle Project also provided services to MSM and other LGBTI people. It was not possible to quantify their MSM-specific services^{vii}(R32, R33).

Figure 16 MSM programming in the Western Cape, 2012-2013

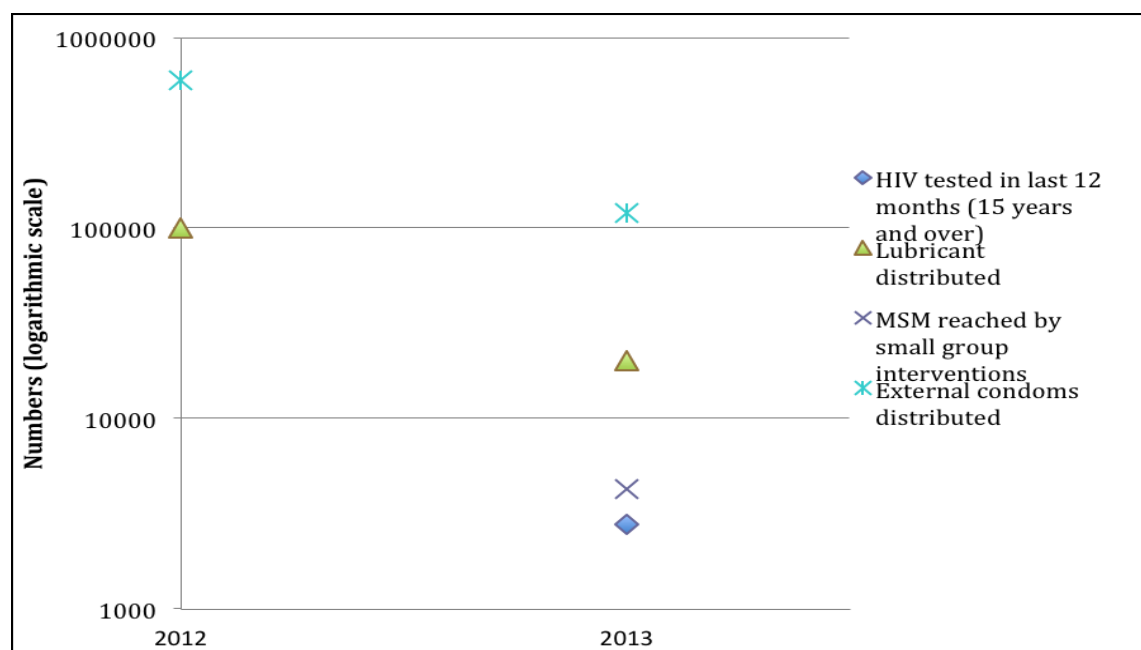


Figure 16 Sources
P6

^{vii} During 2010, Triangle Project provided 170 HIV tests, provided 35 VDRL tests, provided over 1,500 counselling sessions, and facilitated 156 support groups. In 2010 distribution of male sexual packs increased by 183% on figures for 2009. During 2011, Triangle Project created 12 safe spaces in the Western Cape, and conducted 43 VDRL tests and 382 HIV tests.

5.3.2. Hypothesis

- Diverse MSM sub-groups and diverse research methods contributed to the mixed picture.
- Lower HIV prevalence among MSM who have female sexual partners may be linked to risks associated with different behaviours.
- Male sex workers may be increasingly included in MSM-focused programming, which may in turn account for higher levels of reported transactional sex.
- Alcohol use within the MSM community reflected broader community norms.
- Township-based and other MSM sub-groups have only recently been reached through programming efforts and saturation of MSM in these areas with services may not yet have occurred.
- As in other provinces, the drop in the reported distribution of condoms and lubricant may reflect changes in programme funding.

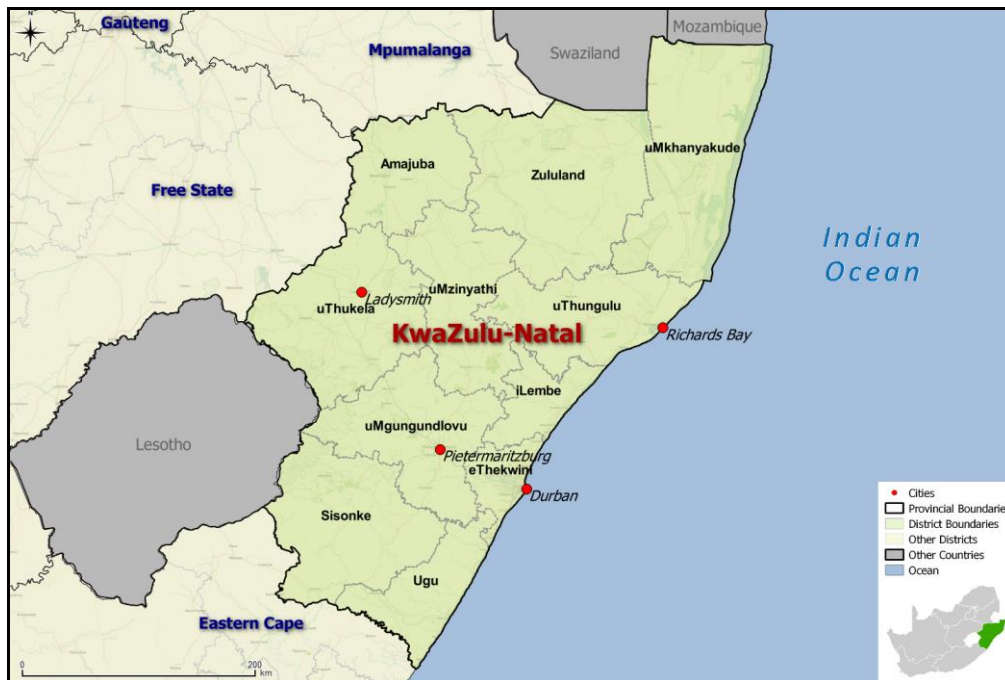
Western Cape Reference List					
CatID	Author	Year	n Size	Method	Location
J33	Burrel et al. ¹³	2008	542 MSM	Convenience	Cape Town (urban centre)
UP1	Brown et al. ³⁸	2011	333 MSM	Convenience	Cape Town (urban and peri-urban)
J2	Baral et al. ⁵⁹	2009	200 MSM	Convenience	Cape Town (peri-urban)
J23	Tucker et al. ¹⁵	2010	117 MSM	Convenience	Cape Town (peri-urban)
R20	Cloete et al. ¹⁰	2013	286 MSM	RDS	Cape Town
D1	Brink et al. ³⁶	2012	50 MSM	Convenience	Stellenbosch University, Western Cape
J20	Eaton et al. ⁴³	2011	143 MSMW	Convenience	Cape Town (peri-urban)
J27	Batist et al. ⁴²	2012	98 MSM	Convenience	Cape Town (peri-urban)
J24	Tucker et al. ⁵⁸	2010	169 MSM	Convenience	Cape Town (peri-urban)
R32	Triangle Project ⁶⁰	2010/11	N/A	Annual report	Cape Town and surrounding areas
P6	ANOVA Health Institute ⁵⁵	2012-2013	N/A	Programmatic data	Cape Town

5.4. KwaZulu-Natal

5.4.1. Snapshot

Background: KwaZulu-Natal (KZN) is situated in the north east of South Africa, bordering the Indian Ocean, Lesotho, Mozambique and Swaziland.

Map 5 Map of KwaZulu-Natal



Approximately 10.7 million people (19.8% of the South African population) live in KZN¹⁸. eThekweni Metro includes Durban, the largest city in the province. In 2011 eThekweni had about 3.4 million residents, with 70% of the population between the ages of 15 and 64 years. The majority of residents in eThekweni are black African (74%), followed by Indian (16.7%) and white (6.6%). Over a third of people in eThekweni have a secondary education (37.1%) and about a third of people are unemployed (30.2%). Pietermaritzburg is the provincial administrative and legislative capital, and is located in the Msunduzi local municipality and uMgungundlovu District. The province is strongly influenced by local cultural beliefs and customs, particularly Zulu and South African Indian culture⁶¹.

LGBTI organisations exist in Durban and Pietermaritzburg and provide the bulk of MSM-focused services. Few gay-friendly leisure spaces and venues exist in eThekweni. Annual gay pride and pageant events have taken place in these cities since the late 2000s. The Durban Lesbian and Gay Community Health Centre houses a MSM-focused clinic (established in 2013) and also provides community safe spaces in Richards Bay, Ladysmith and the South Coast area. Few, if any, services are provided to MSM in rural areas. However, same-sex practices among men in rural KZN have been recorded (J5, CA10).

High levels of homophobia and homophobic attacks have been recorded in KZN. In 2008, several posters for a gay community mobilisation campaign were defaced (R31) and “gay” people were explicitly excluded from attending community events. High levels of verbal abuse and intimidation have been recorded among MSM and LGBTI community members in the Pietermaritzburg area (R31).

HIV epidemic: In 2013 almost half (48.2%) of MSM in Durban were estimated to be living with HIV – 2.58 times higher than the HIV prevalence among males adults aged 15 years and older in KZN, the province with the highest HIV burden in the country (R20), (GP01) (see *Figure 17*).

- In 2008, unadjusted HIV prevalence among MSM in Durban was estimated at 27.5% (J18).
- In 2008, HIV prevalence among MSM in adjacent districts in southern KZN and the northern part of the Eastern Cape was estimated at 24.7%.
- No HIV prevalence estimates are available for other locations or time points.

Prevalence of self-reported STI symptoms: Only one self-reported STI data point exists. In 2013, under half (42.7%) of MSM in Durban were estimated to have had symptoms of an STI in the previous 12 months (R20) (see *Figure 17*).

Figure 17 HIV and STI prevalence among MSM in KwaZulu-Natal, 2008-2013

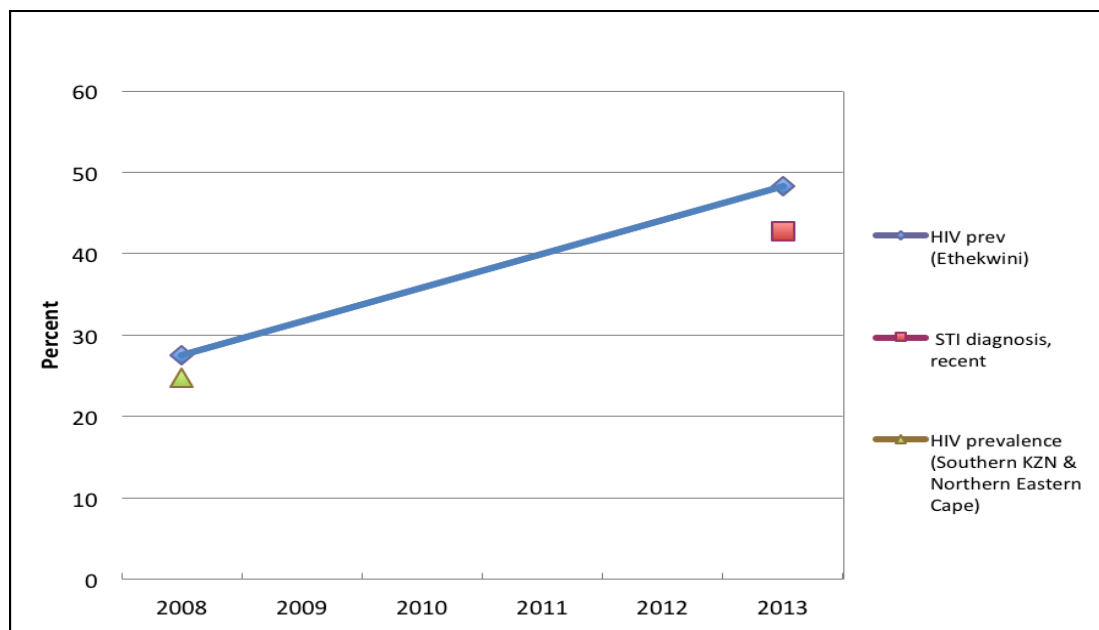


Figure 17 Sources	
HIV prevalence, eThekwini: J18, CA10, R20	STI prevalence: R20
HIV prevalence, Southern KwaZulu-Natal and Northern Eastern Cape: J05	

Risk factors: Generally speaking, HIV risk practices among MSM in KZN were high (see *Figure 18*).

- Alcohol usage around sexual encounters increased throughout the period.
- Exchange sex was present in both rural and metropolitan MSM communities.
- More than half of MSM (55.6%) had three or more male sexual partners in the previous six months. Additionally, 23.0% of MSM also reported engaging in vaginal sex during the same period (not shown).
- Data suggests a slight decrease in UAI (yet it remains high) between 2008 and 2013 (J5, R20).

Human rights violations: Research among MSM in Johannesburg and Durban in 2008 highlighted high levels of stigma and discrimination towards MSM accessing public-health facilities, and that over half (62.3%) preferred to access health services at an MSM centre (versus 6.8% preferring a government clinic) (J51).

Access to health care: Most MSM in Durban have had a recent HIV test and access MSM-focused and public-health facilities (see *Figure 18*).

- In 2013, about three quarters of MSM in Durban (72.3%) had a recent HIV test and knew their test result (R20).
- Data was limited in rural settings; in one study however, a rural sample of seven MSM reported recent testing for HIV (J5).
- In 2013, similar proportions of MSM in Durban accessed HIV testing at gay-friendly clinics and public hospitals (25.7% and 25.8% respectively) (R20).

Figure 18 Risk factors and health-seeking practices among MSM in KwaZulu-Natal, 2008-2013

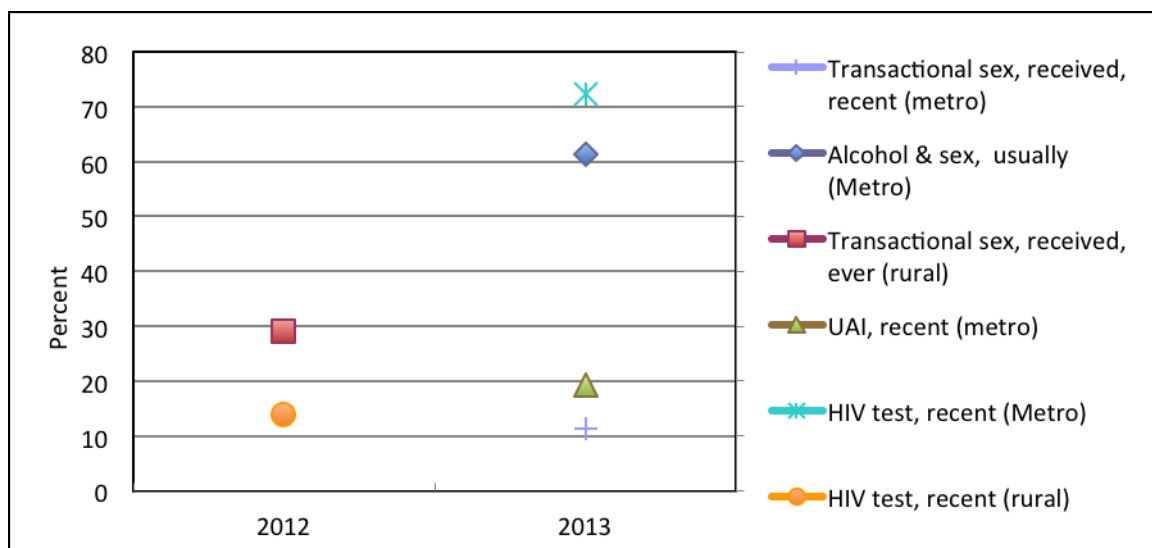


Figure 18 Sources	
Transactional sex, received, ever (rural): J5	HIV test, recent (eThekweni metro): R20
Transactional sex, received, recent (eThekweni metro): R20	Alcohol in the context of sexual encounter: J20
HIV test, recent (rural): J5	UAI: (eThekweni metro): R20

Note: Recent refers to last 12 months

Programming: Data for HIV service provision for MSM was only available from 2012 from eThekweni and uMgungundlovu districts and showed increased provision of condoms (internal and external) and lubricant, and increased access to HIV testing and one-on-one and small-group behaviour-change interventions (see *Figure 19*) (P11, P12):

- External condom distribution increased from 2,552 units in 2012 to 158,897 units in 2013
- Internal condom distribution increased from 712 units in 2012 to 7,352 units in 2013
- Lubricant distribution increased from 2,772 units in 2012 to 15,370 units in 2013
- 950 MSM underwent HCT and received their results in 2013, and
- Participation in small group interventions increased from 1,472 MSM in 2012 to 6,506 in 2013.

Figure 19 MSM-focused programming in KwaZulu-Natal, 2012-2013

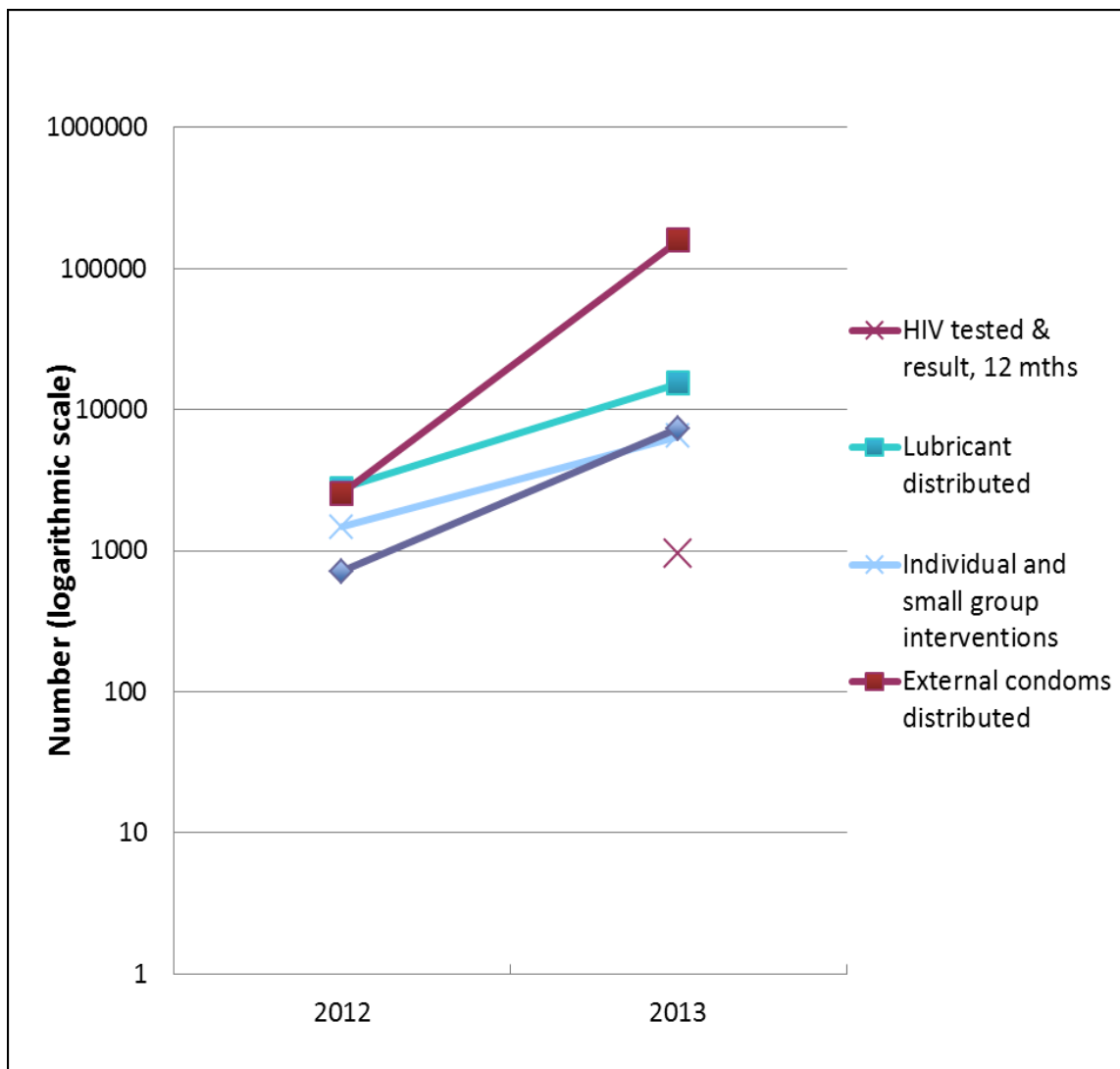


Figure 19 Sources
Programming: P11, P12

5.4.2. Hypothesis

- HIV prevention interventions for MSM in Durban have not reached enough MSM to change the course of the HIV epidemic in this population. A high frequency of unprotected sexual acts was likely to cause the high numbers of new HIV infections, as supported by the number of recent STIs and increased HIV prevalence.
- Recent campaigns around HIV testing in the general population and as part of MSM-focused services in Durban were contributing to high levels of HIV testing among MSM.
- Multiple factors that have been associated with high HIV risk were present in KZN MSM communities, including high levels of alcohol use associated with sex, UAI and transactional sex.
- Given high levels of STI and HIV prevalence, it is likely that UAI has been underreported.
- Efforts to sensitise and training health-care workers about MSM health service needs in eThekweni could be contributing to the equal numbers of MSM accessing services through MSM-focused services and through public services.
- Access to condoms and lubricant appeared to be increasing.

KwaZulu-Natal Reference List					
CatID	Author	Year	n Size	Method	Location
R31	Gay and Lesbian Network, Pietermaritzburg ⁶²	2010	N/A	FGDs and interviews	Pietermaritzburg
J05	Imrie et al. ⁶³	2012	7	Convenience	Northern KwaZulu-Natal (rural)
CA10 & J4	Dunkle et al. ^{23,64}	2008	73 MSM	HH survey	Southern KwaZulu-Natal and northern part of Eastern Cape (rural)
J18	Rispel et al. ²⁹	2008	285	RDS	Durban (eThekweni) and Johannesburg
R20	Cloete et al. ¹⁰	2013	290 MSM	RDS	Durban (eThekweni)
J51	Rispel et al. ¹⁶	2008	285	RDS, FGDs & interviews	Durban (eThekweni) and Johannesburg
R31	Gay and Lesbian Network, Pietermaritzburg ⁶⁵	2011	1301 Grade 10 learners from 7 schools	Survey conducted at schools selected using stratified random sampling	Pietermaritzburg
P11 - P12	ICAP at Columbia University ⁴⁷	2013	N/A	Programmatic data	Durban and Pietermaritzburg

5.5. Eastern Cape

5.5.1. Snapshot

Background: The Eastern Cape is the second largest province and borders the Western Cape, the Northern Cape, the Free State and KwaZulu-Natal, as well as Lesotho in the north and the Indian Ocean to the east. The Nelson Mandela Bay Metro includes the largest city (Port Elizabeth) and surrounding manufacturing and agricultural towns. The province has three ports.

Map 6 Map of the Eastern Cape



In 2011, there were an estimated 1.15 million people living in the Nelson Mandela metropole. Bhisho is the administrative capital of the province. This largely rural province has the lowest expected annual growth rate of South African provinces⁶⁶.

Traditional culture and leaders play a significant role in this province. Few traditional leaders are supportive of same-sex practices, and some have attempted to alter legislation protecting the rights of LGBTI people and to increase the powers of traditional leadership under the proposed Traditional Country Bill (PS01).

MSM and LGBTI community based organisations exist in Port Elizabeth and East London, and provide a limited scope of HIV-related services. Newer grassroot organisations are being established in smaller towns.

Engagement and mobilisation in the province is limited, but a march occurred in 2013 highlighting threats to the rights of MSM and LGBTI people owing to the non-supportive policies of traditional leaders. Annual gay pride marches have been held in East London and in Port Elizabeth since 2010 and 2011 respectively⁶⁷.

HIV epidemic: HIV prevalence among MSM in the northern part of the Eastern Cape and Southern KZN was estimated at 24.7% in 2008 (J4). Self-reported HIV prevalence among 18 MSM participating in a qualitative study in Port Elizabeth was 28% (J48) (Figure 20). HIV prevalence in 2012 among men aged 15 years and older in the Eastern Cape was estimated at 14% (GP01).

Prevalence of self-reported STIs: No data was available.

Risk factors, access to health care: Little data existed on risk practices among MSM in the Eastern Cape. However, existing data among MSM in the Eastern Cape suggested:

- high levels of sexual violence (J4)
- low levels of condom use (J48):
 - In 2012, five out of 18 MSM who took part in a qualitative survey in Port Elizabeth reported to have never used condoms at last anal sex.

Human rights violations:

- Data suggests high levels of sexual violence (J4):
 - In 2008, a third (33.4%) of MSM from the northern part of the EC and Southern KZN were estimated to have been victims of sexual violence.

Figure 20 HIV prevalence and risk practices among MSM in the Eastern Cape, 2008-2013

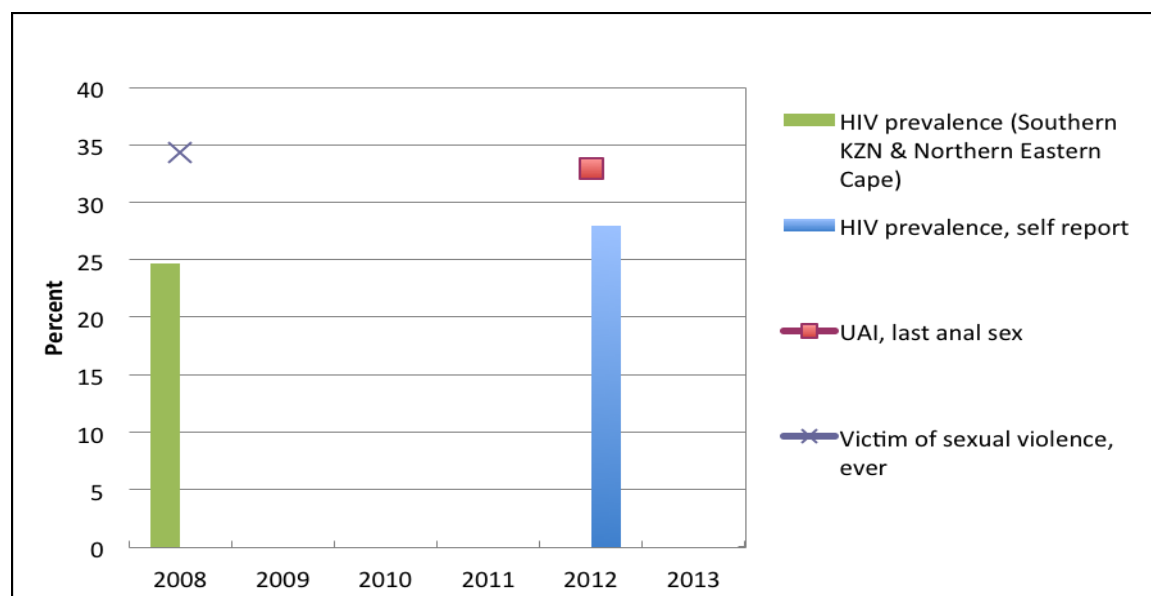


Figure 20 Sources	
HIV prevalence, tested: J4	UAI: J48
HIV prevalence, self-report: J48	Victim of sexual violence: J4

Programming: The limited programmes for MSM are located in Port Elizabeth and East London. A basic package of HIV prevention interventions has been available since 2012, with an increase in commodities distributed and MSM accessing HCT (see *Figure 21*) (P11, P12).

- External condom distribution increased from 7,823 units in 2012 to 60,400 units in 2013
- Internal condom distribution increased from 787 units in 2012 to 6,297 units in 2013
- Lubricant distribution increased from 1,783 units in 2012 to 29,660 units in 2013
- HCT among MSM increased from 247 in 2012 to 987 in 2013, and
- Participation in small group interventions increased from 822 MSM in 2012 to 2,039 in 2013.

Figure 21 HIV programming for MSM in the Eastern Cape, 2012-2013

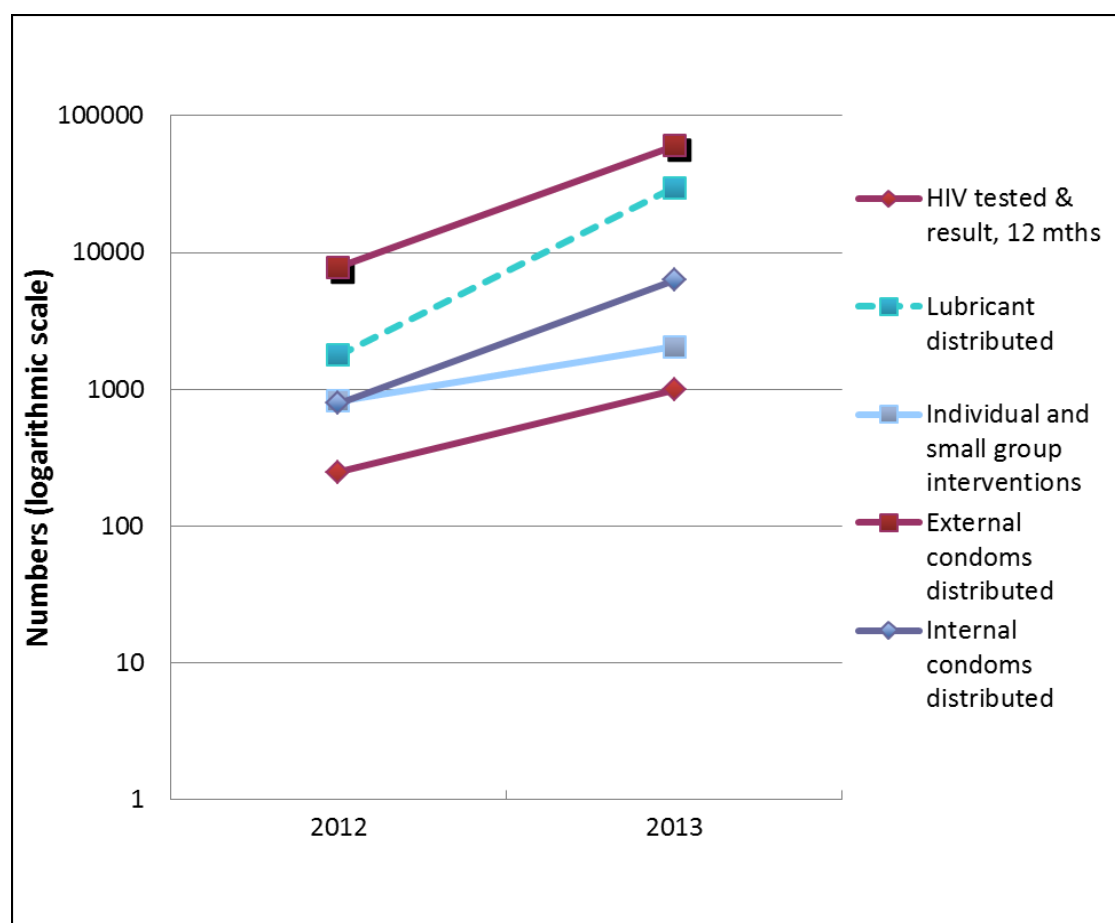


Figure 21 Sources

Programming: P11, P12

5.5.2. Hypothesis

- The lack of data prevents meaningful hypothesis generation.
- High HIV prevalence could be expected owing to high levels of unprotected sex.
- The limited scope and coverage of current MSM programmes means that they are unlikely to significantly alter the HIV epidemic among MSM in this province.

Eastern Cape Reference List					
CatID	Author	Year	n Size	Method	Location
PS01	Eastern Cape Lesbian Gay Bisexual Transgender Intersex Organisation ⁶⁸	2012	N/A	N/A (position statement)	East London
J4	Dunkle et al. ²³	2008	73 MSM	HH survey	Southern KZN and northern part of Eastern Cape (rural)
J48	Siegler et al. ⁶⁹	2012	18 MSM	Convenience, interviews and FGD	Port Elizabeth

5.6. Free State

5.6.1. Snapshot

The Free State province is located in the centre of the country. The province has large agricultural- and mining sectors. Bloemfontein (Mangaung metropole) is the largest urban centre and the administrative centre, and has a population of 747,431, of whom 83.3% are black African. The youth unemployment rate is 37.2% (2011)⁷⁰.

Map 7 Map of the Free State



Limited government interventions for MSM in the Free State have been recorded. In 2009/10, less than 0.2% of HIV and AIDS spending in the Free State was on programmes for MSM, sex workers and people who inject drugs, collectively (CF5).

Several MSM and LGBTI organisations are based in Bloemfontein and provide a limited range of services (R12, R23). MSM bars exist in the city centre with limited MSM-friendly leisure spaces in peri-urban areas (R12). In the province mobile technology and online services are used by MSM with higher income levels to meet partners (R12). Engagement and mobilisation in the province have been limited.

HIV epidemic: No HIV prevalence data existed for MSM in the Free State.

Prevalence of self-reported STI symptoms: No data was available.

Risk factors, access to health care and human rights violations: No quantitative data was available. However, in 2012, a rapid situational assessment of MSM and HIV took place in Bloemfontein and included a focus group discussion with 15 MSM (R12).

- Perceived risk practices identified by participants included:
 - Having sex with multiple sexual partners, while knowing that one is HIV positive
 - Unprotected sex – linked to increased sexual enjoyment
 - Being physically and sexually assaulted and abused
 - Using alcohol and drugs
 - Emotional needs and the need to feel loved
 - Social circumstances (e.g. needing money, food and shelter), and
 - Low levels of knowledge regarding condom and lubricant use.
- Health-seeking practices among MSM were negatively influenced by:
 - Limited condom availability and options
 - Limited accessibility to PEP
 - Limited services for survivors of sexual violence
 - Stigma and discrimination shown towards MSM by health care workers, and
 - Mental health challenges (e.g., anxiety, depression, drugs and alcohol abuse).

Programming: Programmes for MSM have been largely limited to Bloemfontein and surrounding areas. Structured HIV prevention services commenced in 2012, and commodity distribution and MSM uptake of HCT increased (see *Figure 22*) (P11, P12).

- External condom distribution increased from 152 units in 2012 to 1,714 units in 2013.
- Internal condom distribution increased from 96 units in 2012 to 481 units in 2013.
- Lubricant distribution increased from 56 units in 2012 to 2,012 units in 2013.
- HCT among MSM increased from 34 in 2012 to 204 in 2013.
- Participation in small group interventions increased from 206 MSM contacts in 2012 to 1,454 in 2013.

Figure 22 HIV programming for MSM in the Free State, 2012-2013

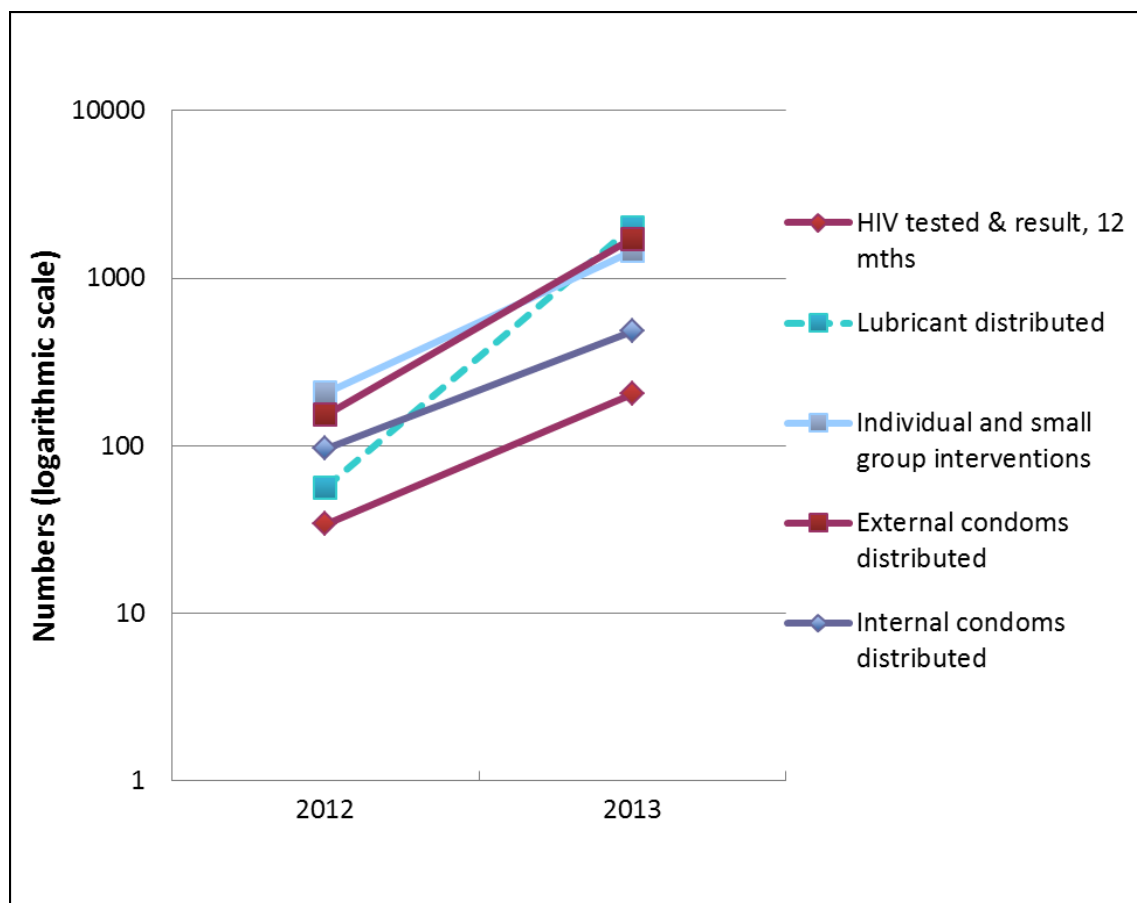


Figure 22 Sources
 Programming: P11, P12

5.6.2. Hypothesis

- The HIV prevalence among men in the general population of the Free State is estimated at 16.1% (GP01). MSM prevalence is likely to be higher, given the rates of UAI and alcohol associated with sex in this population.
- Structured MSM programming has contributed to an increase in the distribution of essential HIV prevention commodities and an increase in HCT, and provided some data for MSM.

Free State Reference List					
CatID	Author	Year	n Size	Method	Location
CF5	South African National AIDS Council ⁷¹	2007/08-2009/10	N/A	AIDS Spending Assessment	Free State
R12	ICAP at Columbia University ⁷²	2013	15 MSM	Convenience, FGD	Bloemfontein
R23	Anova Health Institute ²²	2013	N/A	Situational assessment. Interviews	National, including Bloemfontein
P11 - P12	ICAP at Columbia University ⁴⁷	2013	N/A	Programmatic	Bloemfontein

5.7. Limpopo

5.7.1. Snapshot

The Limpopo province is located in the northern-most part of the country, and borders with Botswana, Zimbabwe and Mozambique. The province has large agricultural and tourism sectors. Polokwane is the capital and also the largest urban centre. The city has a population of 628,999. The youth unemployment rate is 42% (2011)⁷³. Heteronormative norms and values in the province have been identified and prevent disclosure of same-sex practices in the province (R23).

Map 8 Map of Limpopo



Limited government interventions for MSM have been recorded, and in 2009/10, less than 0.12 % of HIV and AIDS spending in Limpopo was spent on programmes for MSM, sex workers and people who inject drugs collectively (CF6).

An LGBTI organisation is based in Polokwane and provides a limited range of services in several districts. MSM bars exist in the city centre with limited MSM-friendly leisure spaces in peri-urban areas (R12). Mobile technology and online services are used by MSM with higher-income levels to meet partners (R12).

Engagement and mobilisation in the province has been limited, with the first gay pride march occurring in Polokwane in 2012 and a Miss Gay Limpopo event in 2013, while sports events, workshops and other engagement activities are gaining momentum (CA54, CA56).

HIV epidemic: No data was available.

Prevalence of self-reported STI symptoms: No data was available.

Risk factors, access to health care and human rights violations: No quantitative data was available.

- Alcohol use in the context of sexual encounters among MSM was common (R23, CA55).
- Ethnographic mapping of MSM in rural Limpopo (CA55) has highlighted other risk factors:
 - Low levels of knowledge around personal HIV risk practices
 - Low motivation for use of condoms during sex, yet reported condom use is high
 - Limited awareness of, and low access to condom-compatible lubricant and use of oil-based lubricants
 - Discrimination towards MSM by community members and health care providers, and
 - Reported intimate partner violence.
- Documented challenges by MSM in accessing health services in Limpopo include (CA54):
 - Fear and mistrust among MSM
 - Low sense of self-esteem and low self-worth among MSM
 - Increased levels of hate crimes, and
 - Stigma and discrimination shown by health workers towards MSM.

Programming: Structured programmes for MSM started in Polokwane (Capricorn) in 2012 (P11, P12). The civil society organisation Limpopo LGBTI Proudly OUT also engages with MSM in the districts of Vhembe (40 MSM), Mopani (102 MSM), Waterberg (130 MSM) and Greater Sekhukhune (294 MSM) (CA54). However, data on commodities and services provided in these districts were not available.

Commodity distribution and uptake of HCT services by MSM in Polokwane increased, but HCT uptake was low (see *Figure 23*).

- External condom distribution increased from 1,142 units in 2012 to 12,618 units in 2013.
- 344 internal condoms were distributed in 2012.
- Lubricant distribution increased from 1,204 units in 2012 to 7,149 units in 2013.
- HCT among MSM increased from 275 in 2012 to 574 in 2013.
- Participation in small group interventions increased from 113 MSM contacts in 2012 to 1,755 in 2013.
- 1,318 MSM have been provided with face-to-face interventions since inception (CA54).

Figure 23 HIV programming for MSM in Limpopo, 2012-2013

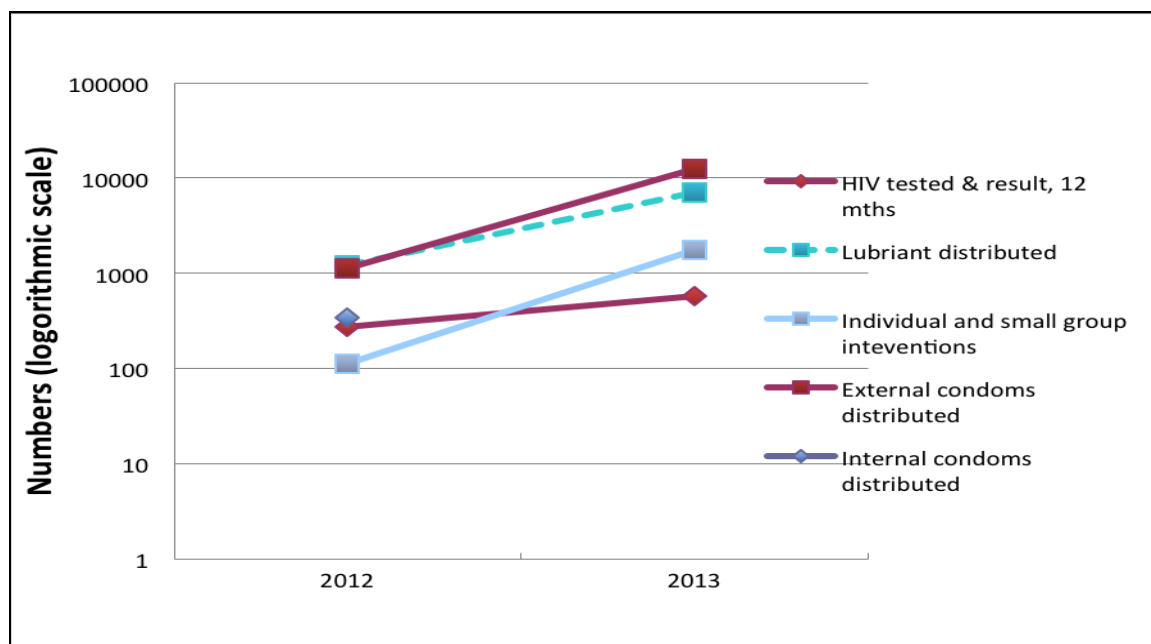


Figure 23 Sources
Programming: P11, P12

5.7.2. Hypothesis

- The HIV prevalence among men in the general population of Limpopo is estimated at 8.9% (GP01). MSM prevalence is likely to be higher, given the association of alcohol with sex and other risk behaviours in this population.
- HIV infection is likely in the context of low knowledge of UAI risks and low lubricant use.
- HIV and STIs are likely to be transmitted to sexual partners in the absence of sensitive, accessible and competent services.

Limpopo Reference List					
CatID	Author	Year	n Size	Method	Location
R23	Anova Health Institute ⁷⁴	2013	N/A	Situational assessment. Interviews	National, including Polokwane
CF6	South African National AIDS Council ⁷⁵	2007/08-2009/10	N/A	AIDS spending assessment	Limpopo
CA54	Limpopo LGBTI Proudly OUT ⁷⁶	2013	N/A	Programme overview	Limpopo (Capricorn, Vhembe, Mopane, Waterberg and Greater Sekhukhune districts)
R12	ICAP at Columbia University ⁷²	2012	Stakeholders	Convenience, interviews	Polokwane
CA55	ANOVA Health Institute ⁷⁷	2013	15 interviews, 3 mapping exercises	Convenience,	Limpopo (Mopane District)
P11 - P12	ICAP at Columbia University ⁴⁷	2013	N/A	Programmatic data	Polokwane

5.8. Mpumalanga

5.8.1. Snapshot

Background: Mpumalanga is a province located in the north-east area of South Africa and borders with both Mozambique and Swaziland. The estimated population of the province in 2014 was 4.2 million people. It is estimated that over half of all males in Mpumalanga are between the ages of 0 and 24 years, and the average life expectancy for males in the province in the period 2011 to 2016 was 56.9 years¹⁸.

Tourism, agriculture, mining and manufacturing all play roles in the provincial economy. Mpumalanga is home to three of the biggest coal-fuelled power stations in the southern hemisphere. Large-scale manufacturing in the province includes chrome alloy and steel⁷⁸.

The provincial capital is Mbombela (formerly known as Nelspruit), and the city is a common stopover for tourists visiting the Kruger National Park. MSM-focused programming is established and growing. Lowveld LGBTI, based in Mbombela, has been operational since 2011. A PEPFAR-sponsored MSM prevention and clinical programming went online in 2013. Gay pride marches were organized in Mbombela and Ermelo in 2014.

Map 9 Map of Mpumalanga



It should be noted the majority of the data below was from a single source (J52), “The Mpumalanga Men’s Study (MPMS): Results of a baseline biological and behavioural HIV surveillance survey in two MSM communities in South Africa”, a respondent-driven sampling study carried out by Lane et al., unless otherwise referenced.

HIV epidemic: A concentrated epidemic exists with a very high prevalence among MSM sub-populations.

- In the Gert Sibande district, the HIV prevalence among MSM is estimated at 28.3%, and in Ehlanzeni district at 13.7%. Among those 25 years or older, the prevalence was 57.8% and 34.5% in Gert Sibande and Ehlanzeni districts, respectively. The HIV prevalence among MSM in Gert Sibande district was 1.95 times higher than the HIV prevalence for adult males in Mpumalanga (GP01). The HIV prevalence among MSM in Ehlanzeni district was the same as for adult males in the province (GP01).
- In Gert Sibande district HIV rates were detected at rates 2.43 and 3.14 times higher than what was estimated for males of similar ages, 25-49 years, in the general population (R37).
- MSM who self-identify as either gay or trans/woman in Gert Sibande district have an HIV prevalence of 39.3% and those identifying similarly in Ehlanzeni district have a prevalence of 13.8%. MSM who identified as bisexual have an HIV prevalence of 20.2% in Gert Sibande district and 21.3% in Ehlanzeni district.

Prevalence of self-reported STI symptoms: Estimates from self-reports in the MPMS show low rates of STIs among MSM in Gert Sibande and Ehlanzeni districts.

- In Gert Sibande district, 5.5% are estimated to have had a sore or ulcers, 3.6% to have had an abnormal discharge, and overall 7.2% are estimated to have had at least one symptom of an STI.
- In Ehlanzeni district, 3.0% were estimated to have had a sore or ulcers; 4.6% were estimated to have had an abnormal discharge; and overall 4.6% were estimated to have had at least one symptom of an STI.

Risk factors: The data available from MPMS suggests that several behavioural risk factors influenced the HIV epidemic among MSM in the Gert Sibande and Ehlanzeni districts:

- Substance abuse among MSM was characterized mainly by hazardous consumption of alcohol and less by other substances.
 - 39.9% of MSM in Gert Sibande and 26.5% of MSM in Ehlanzeni drank six or more alcoholic drinks in one sitting at least twice per month.
- Transactional sex appeared to be relatively common in both Gert Sibande and Ehlanzeni:
 - One of 5 MSM in Gert Sibande received money or other goods in exchange for sex, while roughly 1 of 8 MSM in Ehlanzeni did so.
- Roughly a third of MSM in Gert Sibande and Ehlanzeni reported at least two male sexual partners within the past six months (29.7% and 37.8% respectively).

Figure 24 Risk factors for HIV among MSM in Mpumalanga, 2013

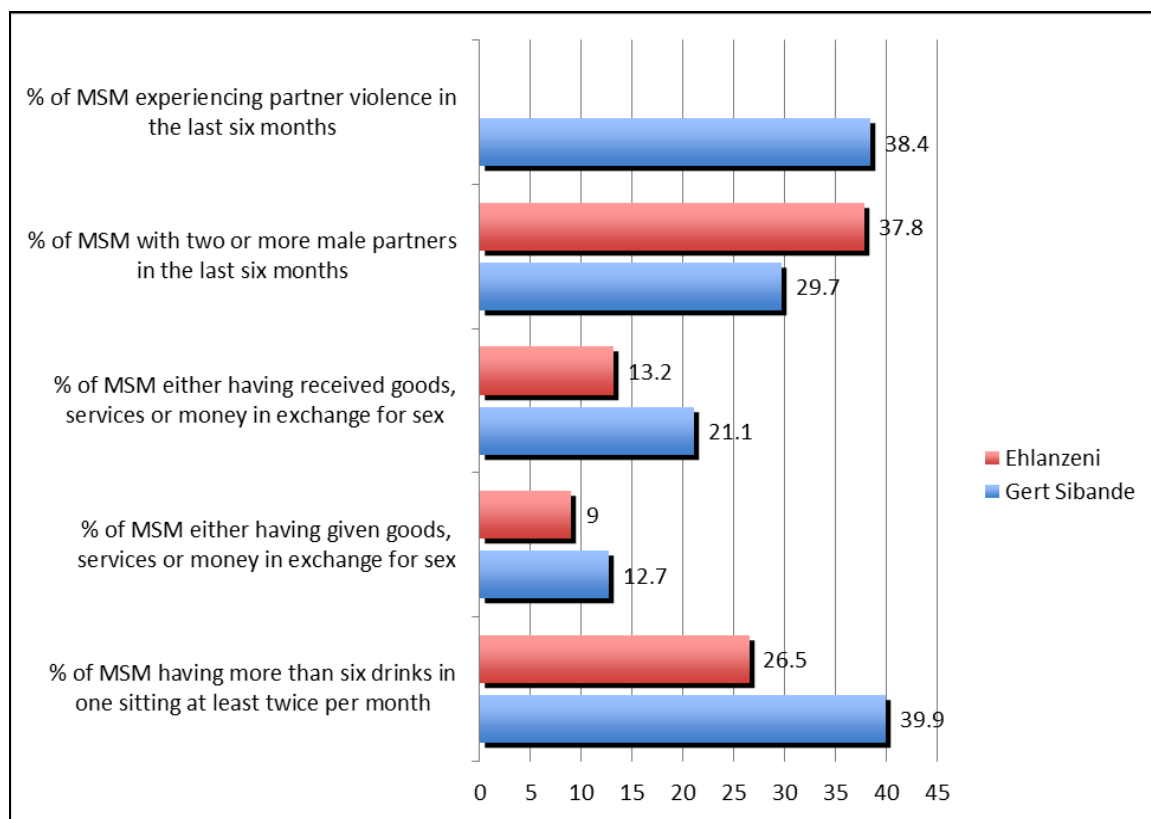


Figure 24 Sources
J52

Human rights violations: Intimate partner violence was common, especially in Gert Sibande district, where 2 of 5 MSM reported recent physical or sexual assault by a male partner.

Access to health care: According to the Mpumalanga Men’s Study, a large majority of Mpumalanga MSM have been tested for HIV at least once in their lives. About half of these men were regular testers (defined by the MPMS as having tested more than once in their lives, and having had their most recent test in the last six months); yet a similar proportion of men have never been tested. In the MPMS, the proportion of the sample of HIV-positive men linked to treatment was very low.

- In Gert Sibande district 65.8% of MSM and in Ehlanzeni district 69.3% of MSM have ever been tested for HIV.
- Approximately one third of MSM in each district could be classified as “regular testers” (defined above) (34.6% and 31% in Gert Sibande and Ehlanzeni districts, respectively).
- A similar proportion of MSM reported never having been tested before, with 34.2% of MSM in Gert Sibande district and 30.7% of MSM in Ehlanzeni district never having previously taken an HIV test.

- Only 18.2% and 11.3% of HIV-positive MSM sampled in the MPMS in the Gert Sibande and Ehlanzeni districts respectively were linked to care, defined as having sought medical attention within 30 days of HIV diagnosis.

Figure 25 HIV testing practices among MSM in Mpumalanga, 2013

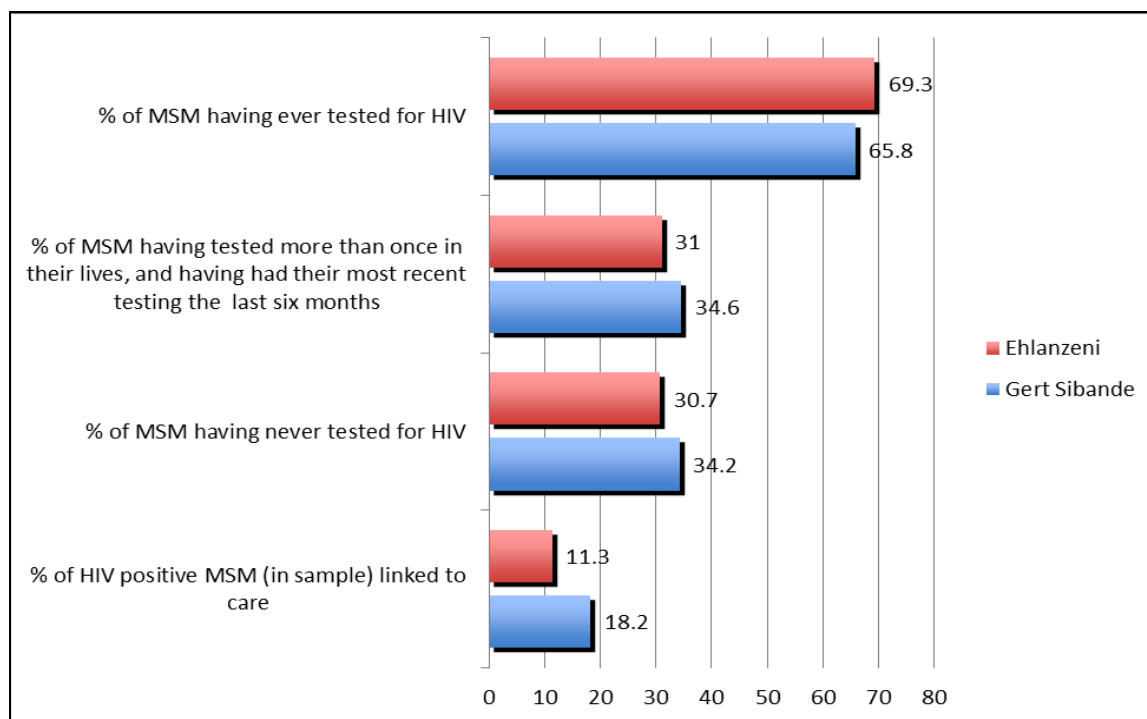


Figure 25 Sources
J52

Programming: Anova’s Health4Men and the UCSF/Anova Boithato Projects are the main actors working specifically on MSM programmes.

- Between October 2011 and October 2012, Health4Men distributed 218,391 condoms, 99,049 lube sachets, and 14,548 IEC materials in Mpumalanga.
- Between April and September 2013, Project Boithato distributed 53,260 condoms, 18,836 lube sachets and 16,100 IEC materials in Gert Sibande district.
- During 2013, 36 Mgroups reached a total of 241 MSM in the Gert Sibande district. (Mgroups are defined as Mpowerment sessions where MSM are informed about condoms and develop skills regarding safer sex negotiation, communication and how to eroticise condoms.)

5.8.2. Hypothesis (Gert Sibande and Ehlanzeni districts)

- Gert Sibande district had the highest general HIV prevalence of all the districts in South Africa, as estimated by the National Antenatal Sentinel HIV and Syphilis Surveillance, which may also account for the high HIV prevalence among MSM in Gert Sibande district.
- MSM most impacted by HIV are also MSM most open about their identity, and thus more reachable by programming and interventions with a focus on the needs of gay and bisexually-identified MSM.
- Low levels of regular HIV testing among MSM and consequent inaccurate knowledge of current HIV status may contribute to high HIV transmission between men in regular partnerships with other men.
- Binge drinking may be associated with high-risk sexual practices.

Mpumalanga Data Sources					
CatID	Author	Year	n Size	Method	Location
R37	Shisana, et al. ⁷⁹	2012	50K++	HH Survey	National
J52	Lane, et al. ¹¹	2013	307+298	RDS	Gert Sibande & Ehlanzeni
GP01	Human Sciences Research Council ⁴⁶	2012	N/A	HH Survey, additional analysis	National

5.9. North West Province

5.9.1. Snapshot

Background: The North West province is a sparsely populated, largely rural province that borders on Namibia, as well as the Northern Cape, Free State, Gauteng and Limpopo Provinces. In 2014, there were an estimated 3,676,300 people living in the province (6.8% of the South African population). The province has a low population density, with the mining and agricultural sectors being the most important in the province (for 2011-2016).¹⁸

Mahikeng is the provincial capital (291,527 people in 2011, 95.5% of whom were black African). Other cities include Rustenburg (549,575 people), Klerksdorp (398,676 people) and Potchefstroom (162,762 people)⁸⁰ (P14).

Map 10 Map of North West province



Grassroots LGBTI organisations have been established in the larger urban areas; however, few receive funding and provide formal services. LGBTI marches have occurred annually in Klerksdorp since 2010, at the North West University's campus in Mafikeng since 2011 and at Potchefstroom campus since 2012 (P13, P14).

Almost no MSM-focused specialized clinics, safe spaces and services are provided in this province. Few MSM-specific locations exist in these large towns, and MSM often socialize in "mixed spaces" (R36).

HIV epidemic: No HIV prevalence data was available for MSM in the North West province.

- HIV incidence among MSM in a cohort study between 2009 and 2011 was 9.5% (J53).
- Self-reported HIV prevalence among 169 MSM participating in a survey in 2010 was 8.8% (R8).
- HIV prevalence among adult men in the North West was estimated at 13.1% (GP01).

Prevalence of self-reported STI symptoms:

- In 2009, 10.4% of MSM who were recruited for an HIV prevention trial in Rustenburg reported having ever had symptoms or having been treated for an STI (R36).

Risk factors: No recent data was available. High-risk practices were recorded among MSM in a 2009 survey conducted among 58 MSM and 818 non-MSM in Rustenburg (R36):

- 10.9% of MSM had a previous symptom or a diagnosis of an STI.
- 44.8% of MSM had previously been tested for HIV.
- 38.5% of MSM sometimes or never used condoms with new sexual partners.
- More MSM had two or more sexual partners in the previous three months compared to non-MSM (70.7% versus 38.9%).
- 25.9% of MSM and their partners had used alcohol around the time of their last sexual act.

High levels of alcohol use were also found in an earlier study among MSM in several cities in the North West, including school going youth (R8).

Figure 26 HIV incidence, prevalence and risk factors among MSM in North West province, 2008-2013

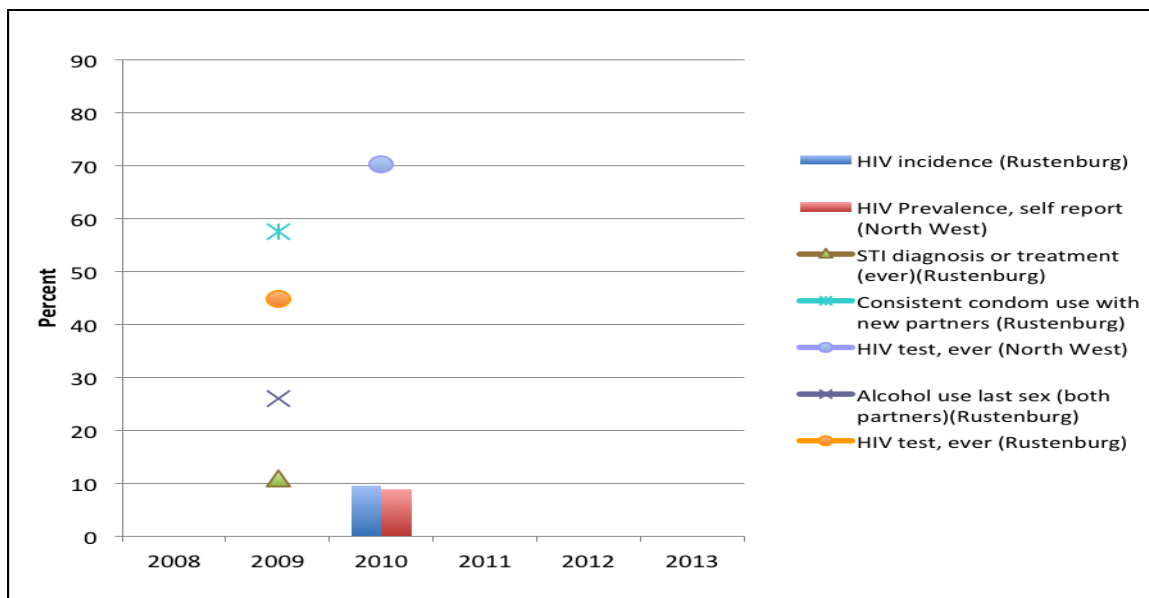


Figure 26 Sources	
HIV incidence, Rustenburg: J53	Alcohol use at last sex, Rustenburg: R36
HIV prevalence, self-report, North West: R8	Condom use with new partner, Rustenburg: R36
HIV testing North West: R8	STI diagnosis or treatment, ever, Rustenburg: R36
HIV testing Rustenburg: R36	
NOTE: Data sources referring to the 'North West' include MSM from multiple cities in that province	

Human rights violations:

- High levels of stigmatization and fear of accessing services in Rustenburg and other locations in the North West have been reported among MSM (R26, R36).
- The attitudes of health facility staff and community homophobic attitudes towards MSM, fear of HIV testing among MSM and safety concerns were some of the barriers limiting access to HIV services for MSM in Rustenburg (R36).

Access to health care:

- Limited data on recent health seeking behaviours were available.
- In 2009/2010, 70.1% of MSM in a North West survey had ever tested for HIV (R8).

Programming:

- Between 2010 and 2011, Gay Umbrella, working with partners (P12):
 - Distributed 350,000 external condoms.
 - Held one small group intervention in each of the four provincial districts.
 - Trained 18 peer educators in HIV prevention, hate crimes, stigma and discrimination and behaviour change interventions for MSM and LGBTI.
 - Conducted a door-to-door HIV testing campaign among MSM and LGBTI people, and tested 90 people from Klerksdorp, Khuma and Mahikeng, of whom half were HIV positive (P12).

5.9.2. Hypothesis

- HIV prevalence in the North West is likely to be higher than self-reports (8.1%), owing to high-risk practices and limited MSM-specific services.

North West Data Sources					
CatID	Author	Year	n Size	Method	Location
P13	HIVOS ⁸¹	2008 - 2013	N.A	Donor support summary	National, including North West Province
P14	Gay Umbrella ⁸²	2008 - 2013	N/A	Programmatic	Four districts of North West Province
R36	Hamilton et al. ⁸³	2009	58 MSM	Convenience	Rustenburg
J53	Kamali et al. ⁸⁴	2010	29 MSM	Convenience, cohort	Rustenburg, North West Province
R8	Baird et al. ³⁴	2009	169 MSM	Convenience	Several cities across North West Province
R26	OUT LGBT Wellbeing ⁵³	2010	N/A	Annual Report	Activities in Gauteng and North West Province
GP01	Human Sciences Research Council ⁴⁶	2012	N/A	HH Survey, additional analysis	National

5.10. Northern Cape

5.10.1. Snapshot

The Northern Cape is the largest and least populated province. It lies between Namibia and Botswana in the North, the Western and Eastern Cape provinces to the South, and the North West and Gauteng provinces to the East.

This largely rural province has a large agricultural and mining sector and several major transport routes linking South Africa to Namibia and Botswana. Kimberley is the capital and the largest urban centre, with a population of 248,041 people, and a youth unemployment rate of 41.7% (2011)⁸⁵. The HIV prevalence among adult males aged 15 to 49 years is 10.9%¹⁹.

Map 11 Map of the Northern Cape



Limited government interventions for MSM have been recorded, and in 2009/10, less than 1% of HIV and AIDS spending in the Northern Cape was allocated to programmes for MSM, sex workers and people who inject drugs collectively (CF4).

Two civil society organisations based in Kimberley provided MSM-focused services in the Northern Cape, and started small-scale service delivery in 2012. In 2014, additional funding for MSM programming in the province was secured (R12, R23). MSM-friendly leisure spaces include taverns and bars (R12). MSM community members have experienced high levels of stigma and discrimination by other MSM community members (R12). Several homophobic attacks have occurred in the province, including the murder of an MSM community member and volunteer for an LGBTI civil society organisation in 2012⁸⁶.

Engagement and mobilisation in the province has been limited, but gay pageants started in Kimberley in the early 2000s and the Out in Africa film festival took place in Kimberley in 2012.

HIV epidemic: No data for HIV prevalence existed for MSM in the Northern Cape. The HIV prevalence among adult men in the province is estimated at 10.9% (GP01).

Prevalence of self-reported STI symptoms: No data was available.

Risk factors, human rights violations and access to health care: No quantitative data was available. However, in 2012, a rapid situational assessment of MSM and HIV took place in Kimberley, and included a focus group discussion with 8 coloured MSM (R12). Perceived risks, as identified by participants, included:

- Frequent changes in sexual partners
- High levels of drug and alcohol use, and
- Sexual violence.

Fears of living with HIV and concerns about the confidentiality of test results were also highlighted by participants as key barriers to accessing HIV testing.

Programming: Structured programmes for MSM started in Kimberley in 2012 (P11, P12). Commodity distribution and uptake of HCT services by MSM in Kimberley has increased (see *Figure 27*).

- External condom distribution increased from 506 units in 2012 to 18,916 units in 2013.
- Internal condom distribution increased from 28 units in 2012 to 7,870 units in 2013.
- Lubricant distribution increased from 55 units in 2012 to 13,554 units in 2013.
- HCT among MSM increased from 66 in 2012 to 549 in 2013.
- Participation in small group interventions increased from 236 MSM in 2012 to 927 in 2013.

Figure 27 MSM programming in Northern Cape, 2012-2013

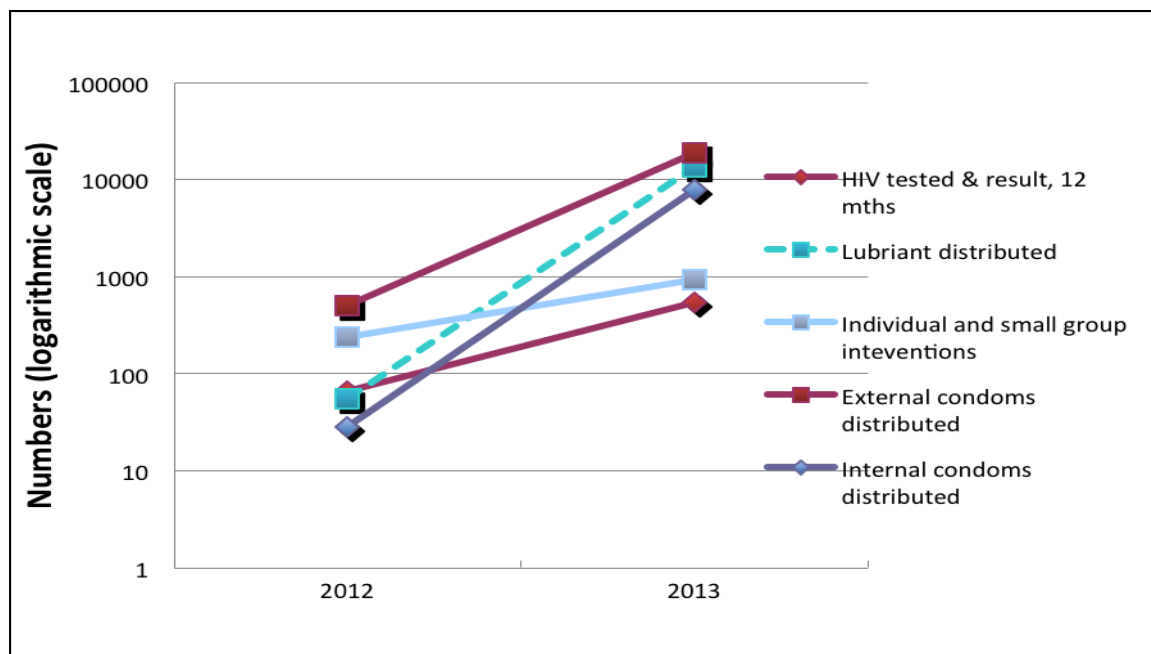


Figure 27 Sources	
P11 – 12	

5.10.2. Hypothesis

- HIV prevalence among MSM is likely to be at least as high as that of all adult men in the province (10.9%), and is more likely to be higher owing to the high levels of risk practices described in qualitative assessments and the limited MSM-focused services to date.
- Uptake of services for MSM is increasing as focused interventions are scaled up.

Northern Cape Data Sources					
CatID	Author	Year	n Size	Method	Location
CF4	South African National AIDS Council ⁸⁷	2007/08-2009/10	N/A	AIDS Spending Assessment	Northern Cape
R12	ICAP at Columbia University ⁷²	2013	Stakeholders	Convenience, interviews	Kimberley
R23	ANOVA Health Institute ⁷⁴	2013	N/A	Situational assessment. Interviews	National, including Kimberley
P11 - P12	ICAP at Columbia University ⁴⁷	2013	N/A	Programmatic	Kimberley

6. Data Gaps

TWG and other MSM stakeholders identified existing data gaps (see Table 1 below). Cells marked with an “X” designate where a data gap exists.

Table 1 Summary of MSM data gaps

Data Gap	National	GP	WC	KZN	EC	FS	LP	MP	NW	NC
Population size estimates for MSM	X	X	X	X	X	X	X	X	X	X
Representative data on HIV prevalence and risk	X	X	X	X	X	X	X	X	X	X
HIV incidence estimates	X	X	X	X	X	X	X	X	X	X
Access, linkage and retention in HIV care and treatment	X	X	X	X	X	X	X	X	X	X
Knowledge and usage of PEP and PrEP	X	X	X	X	X	X	X	X	X	X
STI prevalence data	X	X	X	X	X	X	X	X	X	X
Relationship of recreational drug use and sexual risk	X	X	X	X	X	X	X	X	X	X
MSM-specific data from NDOH HTA programme	X	X	X	X	X	X	X	X	X	X
Data on MSM clinical competency training (policy-makers, managers and health care providers)	X	X	X	X	X	X	X	X	X	X
Evidence on effective interventions in poor low-density and rural areas				X	X	X	X	X	X	X
Data on HIV prevention commodities distributed by civil society organisations and government to MSM			X		X					
Data on MSM-focused services provided by civil society organisations and public facilities					X					
Quantitative data on health service access					X	X	X		X	X

7. Conclusions

The abundance and richness of HIV programming and research data pertaining to MSM in South Africa was unmatched anywhere on the continent. This data included peer-reviewed scientific research, with findings published in academic journals, operational research by NGOs and LGBT CBOs in the larger metros as well as less densely populated provincial cities and towns whose findings have been disseminated in reports to funders and stakeholders, and from the programmatic M&E data provided to increasingly generous philanthropic institutions, the government of South Africa, and foreign governments. From this data, this Triangulation Report has identified several encouraging trends over the 2008-2013 period which align with the goals of South Africa's 2012-16 NSP. These include:

- Increased numbers of MSM who have ever tested for HIV
- Increased distribution and usage of condoms and compatible lubricants
- Greater availability of strategic information through several integrated biological and behavioural surveys and other research

Indeed, the formulation of the current NSP in 2011 was an important statement of principles and commitment of resources required to understand the state of the national response to the epidemic among MSM and all key populations.

Unfortunately, not all data trends point in an encouraging direction. Most alarming of these is that although the number of HIV prevalence estimates has increased, these have consistently shown a high burden of HIV in this population. Most showed nearly a third or more of MSM were already infected with HIV. Although data on HIV care and treatment were limited, they showed that HIV-positive MSM have not been engaged in HIV care and treatment proportionate to their need. Moreover, existing data are not nationally representative, primarily coming from the 5 largest metros: Johannesburg, Cape Town, eThekweni, Tshwane, and Nelson Mandela Bay. While most MSM likely live in these densely populated areas, we know very little about the epidemic in provincial and rural areas. Given what data do exist, it is probably safe to assume that MSM in the countryside remain, on average, more underserved when compared to their metropolitan counterparts. Finally, data from throughout the country indicated that sizeable numbers of MSM consistently experienced forms of stigma, discrimination, violence, and violations of their civil and human rights—serious problems in their own right, and nearly all of which have had associations with greater HIV risk and suboptimal health outcomes in various contexts where they have been systematically studied.

All epidemics are local, and these are the broad strokes of the national picture. Among our primary aims was to capture and synthesize data at the local and provincial levels that could reveal anything about the current state of the epidemic and response, rather than allow data from the largest metros to characterize the rest of the nation. It is our hope that provincial and district level policymakers, health professionals, and program implementers will use this report to understand both what we know, and what remains to be unknown, about how well the HIV services they are providing meet the current needs of MSM, where these services may be falling short, and how to access the resources required to appropriately expand and effectively target their services.

Filling Data Gaps

When stakeholders met in December 2013, we tasked ourselves with answering the question: *To what extent has the response from 2008-2013 matched the state of the HIV epidemic and HIV-related needs among MSM in South Africa?* After 14 months, we concluded that there were critical gaps in data that prevented a definitive answer. Most notably, the public healthcare system did not specifically determine individual risk histories and therefore could not track MSM—or indeed any key population—in terms of current trends in linkage to care and treatment, adherence to ART, and viral suppression. With that said, and despite the great work that has been undertaken by stakeholders and MSM communities throughout the country, that we lack much critical data is itself an unfortunate, if very general answer to the question: *Not well enough.*

Almost no research or programming during the period investigated was national in scope. Indeed, funding for research and programming has been sporadic, project-specific, locally or regionally focused, sponsored primarily by international donors, and dependent upon the capacity of implementing institutions focused regionally rather than nationally. The data triangulation process highlights the fact that the MSM response has been fragmented to date, skewed towards the largest urban centres, and evaluated with inconsistent methodologies and multiple indicators attempting to shed light on common phenomena. In addition, the data gaps we identified related to the most basic of HIV prevention technologies, condom and compatible lubricant distribution, say as much about the inconsistency and unevenness of funding during the period under investigation as they do about the adoption of prevention behaviours among MSM. MSM are everywhere in South Africa, and as far as we may be from fully meeting their needs in the largest metropolitan areas that afford them the most economic opportunity and the greatest measure of freedom from stigma and discrimination, we are farther still from understanding and meeting their needs in the provincial and rural districts that many, perhaps most, grow up in and continue to call home.

Fortunately this is changing, and rapidly as several projects of national scope and significance will come online in 2015, including projects that will inform the response in less well-served provincial and rural areas. In partnership with NDOH, SANAC, the National Institute of Communicable Disease (NICD) laboratory, and national stakeholders, and supported by PEPFAR and CDC-South Africa, UCSF will be collaborating with and providing technical assistance to the Anova Health Institute and the HSRC to implement IBBS with MSM at sites in the Eastern Cape, Free State, Limpopo, Gauteng and North West provinces in 2015, with the aim to identify additional funding for regular HIV surveillance with MSM in all 9 provinces by the end of 2016. We anticipate these efforts will help fill critical data gaps, in particular:

- The size of the MSM population in provincial and rural areas
- Access to and regular utilisation of HCT
- Other prevention programme coverage and utilisation
- Characterization of continuum of care outcomes for MSM
- A national HIV incidence estimate

NACOSA and HSRC, sponsored by PEPFAR and the Global Fund to Fight HIV, TB, and Malaria, are also implementing a national key populations size estimation for MSM, Sex Workers, Transgender persons, and PWID.

The HSRC and Desmond Tutu HIV Foundation are currently collaborating with The Johns Hopkins University's Bloomberg School of Public Health and Emory University's Rollins School of Public Health on a US NIH-sponsored research study that will inform the delivery of combination HIV prevention approaches, including PrEP, in Nelson Mandela Bay and Cape metros, and on a PEPFAR-sponsored implementation science research throughout South Africa that will evaluate approaches to identify HIV-positive MSM and assess clinical outcomes across the care continuum.

Finally, the Anova Health Institute continues to expand its successful PEPFAR-sponsored Health4Men prevention, testing, and treatment approach to MSM with additional sponsorship from the Elton John AIDS Foundation. ICAP will also continue with their PEPFAR-sponsored MSM HIV prevention programme that is operational in several provinces.

With these collaborative programmes, South African stakeholders are on track to make significant strides against the epidemic among MSM, and also in their ability to evaluate the effectiveness of these investments. Were we to conduct a data triangulation again in 4 or 5 years, we anticipate being able to answer this question affirmatively with more complete, nationally representative data that reflects the synergistic effects of these efforts.

8. Recommendations

The following recommendations were developed from the data triangulation process and take into South African and international guidelines on best practices into consideration. National recommendations listed below are applicable across all provinces. Key recommendations have been highlighted at the provincial level where relevant.

1. Increase availability, awareness and access to a standard package of MSM-specific HIV prevention tools and services, including condoms and condom-compatible lubricant, STI testing and treatment, MSM-competent HIV counselling and testing, treatment, and PEP.

National:

- In aggregate, the data suggest that most MSM have tested at least once. However, according to draft national guidelines, repeat testing should be conducted every three to six months among key populations. These draft guidelines should be adopted and immediately implemented in all HIV testing programmes for MSM across provinces.
- Asymptomatic STI testing protocols should be developed and implemented.
- Condom and lubricant distribution needs to conform to a one-to-one ratio for MSM.
- Programmatic efforts to provide health care sensitisation and competency training should continue where they already exist and need to expand in all provinces.
- National guidelines exist for the use of PEP following sexual exposure to HIV. These guidelines need to be implemented across provinces and efforts need to be made to educate MSM and healthcare providers regarding the use of PEP among MSM.

Gauteng:

- Uptake of HIV testing is increasing, and the programmatic focus on HIV testing needs to continue and expand.
- The programmatic response focusing on condoms and lubricant to MSM might not be sufficient to reach the population. Efforts should be increased.

Western Cape:

- Procurement and distribution of condoms and lubricant needs to continue and expand beyond the metropolitan area.
- Increased awareness of and treatment for STIs, including asymptomatic STIs, should be expanded.
- Guidelines for PEP do not align with the national guidelines, and therefore may prevent MSM from accessing this prevention tool. All MSM who are HIV-negative and exposed to HIV should be offered PEP to prevent new HIV infections.

KwaZulu-Natal:

- MSM-focused HIV prevention interventions in eThekweni and Pietermaritzburg exist, and should continue and expand into additional communities.

Eastern Cape:

- Focus on increasing access to HIV counselling and testing, improving the distribution of HIV prevention commodities, and enhancing programming efforts to increase education regarding HIV testing, prevention and care.
- Efforts are needed to increase service coverage beyond Port Elizabeth and East London.

Limpopo / Northern Cape / North West / Free State:

- Little work had commenced in these provinces during the time period under review (2008-2013). Efforts to increase access to HCT, HIV care and STI treatment are an essential first step to meeting the needs of MSM in Limpopo, North West, the Free State and the Northern Cape.

Mpumalanga:

- Broadened uptake of HCT is required (including a focus on male couples and younger MSM).

2. Increase availability, awareness and access to an enhanced package of MSM-specific HIV prevention tools, such as proven biomedical prevention strategies, including PrEP and TasP

National:

- Findings from PrEP demonstration projects launched in 2015 in Gauteng and Western Cape should be incorporated into programmatic responses in all provinces.
- Current South African guidelines that do not allow for the immediate initiation of ART for MSM who test HIV positive should be re-evaluated, given the abundant evidence of high risk practices and a high prevalence epidemic among MSM.

3. Increase availability of, awareness of and access to appropriate, acceptable and MSM-competent health-care services, including mental health services, and with a specific focus on linkage to and retention in HIV, TB & STI care and treatment

National:

- MSM sensitisation and competency training is not integrated into national training programmes, and should be considered for roll-out in such structures as the regional training centres, medical schools, and nursing colleges. Clinic level sensitisation training has been conducted mainly in Gauteng, Limpopo, Eastern Cape, Free State, KwaZulu-Natal, Northern Cape and Western Cape, and needs to continue and expand in all provinces.

4. Identify and implement harm reduction approaches for alcohol and other substance use among MSM

National:

- Across the provinces, alcohol use has been identified as a substantial comorbidity, and is currently unaddressed in programming.
- Some MSM in South Africa also use stimulants and designer drugs (e.g. methamphetamine, Ecstasy and GHB) that impair decision-making and contribute to risk taking in the context of sexual encounters.
- Harm reduction interventions that focus on reducing the health-related harms of alcohol and other substances should be evaluated and included in MSM programming in all provinces.

5. Identify underserved areas and the diversity of MSM subpopulations not currently reached by MSM programming and address their programming needs, such as MSM in rural areas, MSM who engage in sex work, MSM under the age of 25 years, MSMW and those identifying as bi-sexual.

National:

- MSM programming currently targets metropolitan areas and should be expanded to peri-urban and rural communities that are currently underserved. Programming needs to be tailored to target high-risk behaviours, including transactional sex and UAI. Lower HIV prevalence among young MSM highlight the case and opportunity for creating and targeting programming and interventions reinforcing prevention behaviours among young MSM moving into adulthood.

Western Cape / Gauteng / KZN:

- Programming should expand outside of the metropolitan centres and the immediate surrounding communities.

Limpopo / Free State / NC / NW / EC / Mpumalanga:

- Programming needs to be implemented in all areas, using context-appropriate approaches.
- Cost-efficient methods of providing services in areas of low population density need to be explored and developed.

6. Build the capacity of civil society to mobilise MSM for healthy community norms

National:

- Continue efforts to support MSM and LGBTI organisations to provide community-based prevention, linkage to care and support services for MSM.
- Support the establishment of MSM and LGBTI organisations in peri-urban areas and other areas.
- Link organisations working with MSM to formal programmes to increase coverage, coordination and sustainability.

- Support MSM and LGBTI organisations to develop contextually relevant strategies that aim to build social capital and agency of MSM and LGBTI people, their organisations and their communities.
- Enable linkage, mentorship and learning opportunities between nascent and established MSM and LGBTI organisations.
- Provide organisational developmental of MSM and LGBTI organisations to improve their governance, implementation, M&E and financial structures with a view towards sustainability.
- Build the capacity of grassroots organisations to provide MSM-competent HIV services in efficient ways.
- Develop innovative ways for local groups to provide services to MSM and link with local health services in rural contexts, including the use of digital technology and social media.

7. Address social and structural factors driving the HIV epidemic among MSM, including developing and expanding programmes to mitigate stigma and discrimination owing to homophobia and HIV serostatus

National:

- MSM have reported experiencing stigma and discrimination in health-care environments, which has negatively affected their access to services and retention in care. Stigma and discrimination must be systematically addressed through sensitisation and competency training of health-care workers, social workers, police, educators and community leaders.
 - Programming that promotes awareness of MSM rights and enhances access to legal and social services in response to experienced stigma and discrimination should be expanded to address these issues.
 - Qualitative research shows that MSM are at increased vulnerability to HIV and its consequences due to structural factors, particularly exclusion, poverty, violence and unemployment. These issues need to be addressed in MSM programming to increase social capital and increase the agency of MSM to make empowered decisions and to realize their potential.
- 8. As recommended in the 2012-2016 NSP, implement routine collection and utilisation of strategic information using standardized measures to identify knowledge and programming gaps across multiple sectors (i.e. develop and implement a surveillance system that includes HIV epidemiology and health service access among MSM). Funding for surveillance must be sufficient to ensure that nationally representative and generalizable bio-behavioural data are collected at regular intervals (i.e. annually or biannually). We strongly recommend that bio-behavioural surveillance include HIV incidence, as well as other biological markers, including bacterial and viral STIs. These include syphilis, gonorrhoea, chlamydia, hepatitis B virus, and hepatitis C virus. We further recommend initiating and supporting a stakeholder advisory body to facilitate coordination and integration of surveillance with other HIV research priorities.**

National:

- Coordinate planning and implementation of research and surveillance to address data gaps and monitor impact of programmes (see also Chapter 6). Specific research and strategic information gaps should be addressed by:
 - Conducting population size estimates.
 - Conducting representative HIV prevalence and incidence estimates.
 - Collecting programmatic data on MSM, ART and MSM receiving treatment for sexual health conditions.
 - DOH should categorise data on HIV and sexual health and treatment per KP group, including those accessing ART.
 - Track STI testing among MSM (several STIs are markers of high risk sexual practices) will assist in obtaining a more descriptive risk profile of MSM
 - Monitor retention of MSM in the HIV cascade (from HIV testing to viral suppression on ART), and identify areas where interventions can be implemented to reduce loss to follow-up.
 - Standardise methods and tools used to report on HIV and related services provided to MSM.
 - Collect HIV epidemiology, sexual risk practices and health seeking practices among adolescent and young MSM.
 - Implement and evaluate pilot interventions to assess feasibility and cost-effectiveness of new biomedical interventions, specifically PrEP and TasP for MSM.
 - Trend analysis should be undertaken once follow-up RDS data from Gert Sibande and Ehlanzeni districts has been collected. Similar analysis should be undertaken where repeat RDS surveys are completed.

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10. Appendix: TWG Terms of Reference

South Africa MSM Data Triangulation Technical Working Group (TWG)

The South Africa MSM Data Triangulation Technical Working Group is an assembly of experts familiar with the HIV epidemic and the HIV-related needs of MSM in South Africa. The group provides oversight in the collection and cataloguing of MSM-related data and the synthesis of that data with reference to answering the TWG's main data triangulation question:

To what extent has the response from 2008-2013 matched the state of the HIV epidemic and HIV-related needs among MSM in South Africa?

I. Activity Background

This MSM Data Triangulation activity proposes to compare results from multiple existing data sources to answer key questions that were developed through a consensus process conducted in September and December 2013 with South Africa in-country MSM stakeholders. The data triangulation process includes the identification, collection, review, collation, synthesis, analysis, and interpretation of secondary data from multiple sources. No primary data collection will be involved. The results of this synthesis, analysis, and interpretation process may be used to inform policy and programmatic decisions and to enhance and improve Prevention and Care & Treatment programmes for MSM in South Africa. Specifically this process will provide information that could inform progress made towards meeting HIV commitments for MSM (e.g. provide information that could feed into the National Strategic Plan 2012- 2016 mid-term review and the National High Level Meeting on AIDS (UNGASS) reporting processes).

II. Objectives of TWG

To recommend and provide assistance in obtaining data that bear upon the TWG's main MSM data triangulation question.

To ensure that sound and comprehensive data is collected from all MSM stakeholders in a systematic and cohesive manner.

To assist in the development of a project summary report intended for all MSM stakeholders, including SANAC and NDOH.

III. Responsibilities of TWG members

Members of the TWG will participate in monthly meetings/tele-conferences during the data triangulation process to ensure adherence to the activity timeline and to develop any process or strategy recommendations. Additional meetings may be deemed necessary based on these monthly proceedings.

The TWG will support the data mining team in gaining access to MSM stakeholders, assist the data mining team to access relevant information and aid with any obstacles that are encountered.

The TWG will regularly appraise catalogued data for appropriateness to the data triangulation questions and to determine the overall coverage and gaps in data collected to date.

Upon completion of the data triangulation process, the TWG will develop a hypothesis of collected data, reporting on strengths and weaknesses of the process, and subsequently, provide recommendations for MSM policy-makers, programmes, and other stakeholders to ensure that the ongoing response is appropriate to the HIV-related needs of MSM in South Africa.

IV. Governance

Chair: A UCSF Technical Advisor will chair each meeting. The Chair will be the person responsible for scheduling meetings and setting each meeting's agenda.

Minutes: A Secretary will be appointed from Anova Health. The Secretary will be responsible for recording minutes and submitting them to the UCSF Technical Advisor within 48 hours of the conclusion of a meeting.

Draft minutes will be submitted to the TWG by the Technical Advisor no later than 24 hours in advance of the next scheduled meeting.

Minutes may be amended and adopted by a majority vote of a quorum (50%+1) of constituent members of the TWG present.

Members will be allowed to amend minutes via e-mail in the event that they are not present for a meeting. Any member who submits amended minutes via e-mail in advance of a meeting will be counted as "present" for purposes of establishing a quorum, and his/her vote to adopt minutes as amended, will be tallied with an "aye".

Decision making: Members of the group agree to keep the organizational leadership whom they represent informed of the proceedings of the TWG. They also agree to seek authority to make decisions on behalf of the organization as deemed appropriate during regular meetings. In the event that organizational decisions cannot be made at the time of a meeting, members will report decisions back to the TWG in a time-frame that is agreed upon by consensus.

V. Timeline

Data Collection Activities: To commence in February 2014.

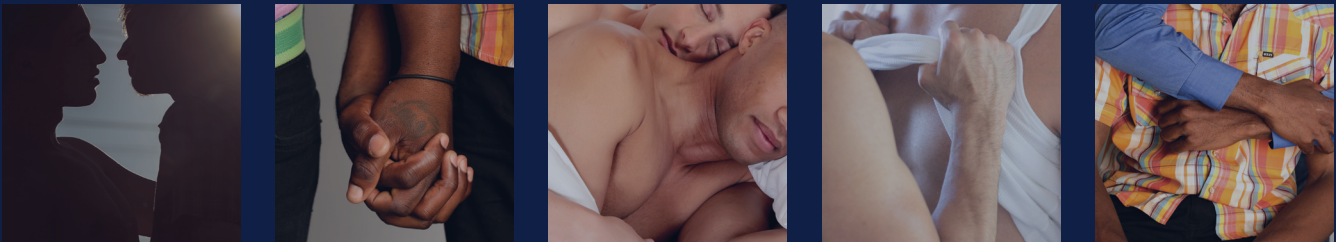
Project Summary Report: Anticipated for delivery in Q3 of Calendar Year 2014.

_____ / ____ / 2014

Signature & Printed Name

Date

_____ Name of Organization



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