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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

EHPSA EVIDENCE BRIEF
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THE TRANSFORM STUDY

Strengthening the design of HIV prevention interventions for men who have sex with men in Kenya and South Africa

INTRODUCTION

The TRANSFORM study aimed to assess what HIV prevention and care interventions are feasible, acceptable and needed by MSM in the current socio-political climate of Nairobi, Kenya and Johannesburg, South Africa.

The TRANSFORM study was led by Wits Reproductive Health Institute (Wits RHI) in partnership with the University of Manitoba/Partners for Health and Development in Africa (PHDA), The London School of Hygiene and Tropical Medicine and University of Oxford.

WHY THIS STUDY IS IMPORTANT

Kenya and South Africa have large generalised HIV epidemics, but it is increasingly recognised that key populations, including MSM, are disproportionately affected. At the same time, MSM have been substantially under-served by HIV prevention and care programmes. To add complexity to this challenge, in both these countries, MSM are a diverse population that include a broad range of identities. They range from those who are openly gay, to those who identify as transgender or heterosexual and have concurrent partnerships with women.

This study fills some critical gaps in the knowledge base of the diversity of MSM experience within their communities and in health care seeking and will therefore strengthen the design of HIV prevention programmes for them in Kenya and South Africa.

APPROACH

In Phase One of the study, in-depth interviews were done with 30 participants in Johannesburg and 31 participants in Nairobi to understand their HIV risk and health-seeking behavior.

In Phase Two, participants were recruited by Respondent Driven Sampling (RDS) - 301 in Johannesburg and 618 in Nairobi. They were interviewed and screened for HIV and STIs.

KEY FINDINGS

Early and continuous engagement of MSM community stakeholders in the study contributed to the success of the project. The study also found that, in both countries, MSM suffer rampant stigma and discrimination perpetrated by members of the general population and health care providers. This was experienced more by MSM who presented as feminine, or who cross-dressed.

1. Population size estimates

The Nairobi study estimated population size of MSM to be 20,000 in Nairobi County. This is in line with other estimates that have been made for that County.

2. Prevalence of HIV and STIs

High HIV prevalence among participants was noted: 37.5% in Johannesburg and 26.4% in Nairobi. Prevalence increased with age of participants in both sites.

3. HIV care cascade

At the Johannesburg site 56% of those who were HIV-positive knew their status and of those, 30% were on antiretroviral therapy and 49.4% were virally suppressed. Thus, viral suppression falls well short of the UNAIDS target of 73%.

In the Nairobi arm of the study HIV diagnosis represented the weakest link in the continuum of care, with only 73% of HIV-positive men aware of their status (in comparison with the 90% of the UNAIDS target). Of those, 83% were on treatment and of those, 83% were virally suppressed. Undiagnosed HIV infection, ie from those not already in care, accounted for over 80% of the viral load in that population.

4. Burden of sexually transmitted infections (STIs)

The study found a high burden of STIs, including an appreciable percentage that were asymptomatic. For example, the prevalence of rectal gonorrhoeae (GC) and chlamydia (CT), in the Nairobi group was 13.3% and 8.7% respectively, but only 18% of these cases were symptomatic. This implies that there is a large pool of untreated STIs circulating in this population. In the Johannesburg cohort there were high rates of HSV-2 (40.33%) and syphilis (9.3%).

5. Gender identity

The majority of participants in both Johannesburg and Nairobi identified as gay or bisexual. However, there was also a large group of "closeted" MSM who identified as heterosexual or "undecided". This group was not engaged in HIV prevention and treatment services.

6. Use of social media

At both sites the majority of MSM were active on social media, especially Facebook, WhatsApp and Instagram, and used them for general interactions as well as hook-ups and sexual liaisons. In the Kenyan arm of the study 71% of interviewees had used social media in the previous month.

7. PrEP uptake

Awareness and understanding of PrEP was relatively low at both sites with just over a quarter of negative and untested men being able to correctly describe what PrEP was. In both cities, men stated that they knew what PrEP was but were confusing it with post-exposure prophylaxis (PEP). It was also noted that participants in Johannesburg who had used PEP before, used it for an average of 10.8 days - substantially less than the minimum of 28 days required to receive full benefit of its HIV prevention properties. Uptake of PrEP was low at both sites. Participants also expressed concerns about PrEP side effects and stigmatisation by other community members.

8. Mental health issues and substance abuse

Mental health issues, alcohol abuse and illicit drugs/ substance use are common among MSM in both Nairobi and Johannesburg. At the Nairobi site around 24% of men identified their use of alcohol as being in excess of low risk, or harmful, including 6% who said they were alcohol dependent. The men commonly described how alcohol made them more sexually adventurous and more likely to try group sex or different sex roles.

CONCLUSION

The high levels of psychosocial problems, HIV and STIs among MSM in both countries is of concern. Increasing the capacity of MSM-friendly and community-based providers to offer PrEP and other HIV/STI interventions will be important to address these issues. Prevention approaches that lower biological risks, including those using antiretrovirals, offer promise for epidemic control.

Although health promotion interventions are required to explain the utility of PrEP, the research suggests that free availability would generate substantial demand among MSM especially for injectable/ long term methods.

The high percentage of MSM who use social media represents an opportunity to reach this group with HIV prevention messages. It is particularly promising for hard-to-reach MSM who are not engaged with community-based organisations or HIV services.

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