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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

EHPSA CRITICAL REVIEW
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Sexual health and HIV services for men who have sex with men in eastern and southern Africa

A situational analysis

SUMMARY REPORT

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1. INTRODUCTION

While sexual and gender rights are contested across eastern and southern Africa (ESA), there is increasing attention to ensuring that key populations, including MSM, have access to HIV and sexual health service. To understand the scope and extent of this movement, EHPSA commissioned a situational analysis focussing on seven countries in the region – Kenya, Malawi, Mozambique, Namibia, South Africa, Zambia and Uganda.

This brief report summarises the key findings of the study, which was conducted by a team of researchers from the Human and Social Development (HSD) Programme at the Human Sciences Research Council (HSRC). The full report and an evidence brief are available on the EHPSA website at http://www.ehpsa.org/critical-reviews/msm-services

2. LEGAL CONTEXT FOR MSM SERVICES

Five of the seven study countries currently have discriminatory laws against certain homosexual acts. Homosexual acts have been decriminalised in South Africa (1994) and Mozambique (2016).

TABLE 1: CRIMINALISATION OF SAME SEX ACTIVITIES IN SEVEN ESA COUNTRIES

Country	Discriminatory legislation	Sodomy is illegal	Penalty for homosexual activities
Kenya	Section 163(15) of the Penal Code	Yes	• Attempt to commit sodomy imprisonment for up to seven years • Conviction for committing sodomy imprisonment for up to 14 years
Malawi	• Section 153(07) of the Penal Code of 1930 (revised 2009) • Marriage, Divorce and Family Relations Law of 2015 (Annulled 2015)	Yes	• Attempt to commit sodomy imprisonment for up to seven years • Conviction for committing sodomy imprisonment for up to 14 years
Mozambique	Section 71(4) of the Penal Code of year (revised 2014 reference to "acts against nature" removed)	No	No penalty
Namibia	Criminal Procedure Act of 1977 (revised 2004)	Not officially	No information identified
South Africa	The Immorality Act of 1927, 1957 and 1969 (no longer valid)	No	No penalty
Uganda	• Sections 145, 146 and 148 of the Penal Code of 1950 • Anti-Homosexuality Act of 2014 (Annulled 2014)	Yes	• Attempt to commit sodomy imprisonment for up to seven years • Conviction for committing sodomy imprisonment for up to 14 years • Repeat offenders may be sentenced to life imprisonment • Same-sex marriage is criminalised and carries a life sentence
Zambia	Sections 155-157 of the Penal Code of 1930	Yes	• Attempt to commit sodomy imprisonment for up to 14 years • Conviction for committing sodomy imprisonment for up to 14 years

South Africa is the only study country that explicitly protects LGBTI rights in a number of laws, including same-sex marriage. Namibia also provides some protection against discrimination around sexual orientation in their Labour Act. Beyond constitutional provisions, other laws could be expanded to include protection for MSM populations such as labour laws, domestic violence laws, family laws and inheritance laws etc. Table 2 below provides a summary of actual and potential affirming legislation in the seven countries.

TABLE 2: AFFIRMING LEGISLATION AND POLICY ACTIVITIES IN SEVEN ESA COUNTRIES

Country	Affirming legislation	Affirming policy
Kenya	No information identified	• Provision for MSM with KP programmes outlined in the country's NSP with national KP guidelines published in 2014
Malawi	No information identified	• Provision for MSM with KP programmes outlined in the country's NSP
Mozambique	• Labour Law Article 4 of the 23/2007 • Labour Law Article 5 of the 23/2007	• Provision for MSM with KP programmes outlined in the country's NSP
Namibia	The Hospitals and Health Facilities Act 36 of 1994	• Provision for MSM with KP programmes outlined in the country's NSP • The Ethical Guidelines for Health Professionals • The Patient Charter of 1998 • Provision for human rights of sexual and gender minorities in the Office of the Ombudsman
South Africa	• Section 9(1) of the Constitution • The Civil Union Act No. 17 of 2006 • The Alteration of Sex Descriptions and Sex Status Act of 2003 • The Domestic Violence Act of 2003 • The Rental Housing Act of 1999 • The Employment Equity Act of 1998 • The Medical Schemes Act of 1998 • The Labour Relations Act of 1995	• South African National LGBTI HIV Plan 2017/22 • Provision for MSM with KP programmes outlined in the country's NSP
Uganda	No information identified	• Provision for MSM with KP programmes outlined in the country's NSP
Zambia	No information identified	• Provision for MSM with KP programmes outlined in the country's NSP

In the past four years there have been shifts in the legislative and contextual environment across the region that have had an impact on sexual health and HIV services for MSM. For example, at the time of the present study a large number of clinics in Tanzania were being closed in response to widespread homophobia generated by key political leaders and reported in the media.

Although the media was not a key focus of the present study, the role of the media in influencing the socio-political attitudes regarding MSM across the region should be noted. The state media, as seen in Tanzania, Uganda and Zambia appear to be complicit in state homophobia, which may affect the safety of MSM populations, and their ability to access services.

In many countries, dormant anti-homosexuality legislation is having little effect on implementing sexual health and HIV service provision. Nonetheless, the existence of this legislation makes it particularly difficult to lobby for and implement necessary services in line with country commitments to MSM.

3. POLICY CONTEXT FOR MSM SERVICES

National Strategic Plans (NSP) are fundamental for coordinating the work of key stakeholders in a country's HIV/AIDS response. A review of country NSPs indicated that, despite hostile or ambiguous legal and policy environments, the NSPs of all study countries identify MSM as an at-risk population. In most cases MSM were addressed as a sub-group within strategies for key populations (KP) or most-at- risk populations (MARPS).

The inclusion of HIV prevalence or incidence estimates among MSM across study countries was variable. For example, although estimates for Kenya, Namibia, South Africa and Zambia are available in the literature, these were not included in the NSPs. However, South Africa does include some statistics in its LGBTI HIV Plan 2017/22. This situation reflects the lack of comprehensive HIV surveillance among MSM in the region, including population size estimates. There is agreement across most NSPs that information gaps impede the development of effective programming for MSM, and several countries have identified improved surveillance and information as a goal or strategy in their NSPs.

NSPs frequently acknowledge that the adverse legal and policy frameworks are a barrier to facilitating access to services for KPs, including MSM. To this end, several countries (Kenya, Malawi, and Uganda) have recommended law and policy review or reform. In addition, several NSPs (Kenya, South Africa, and Uganda) articulate plans for anti-stigma and discrimination campaigns or programmes.

Several NSPs identify the importance of improving the capacity of service providers to provide quality and sensitive services to MSM. However, most NSPs fail to include any specific actions to target these populations. Only Kenya and South Africa appear to have KP-specific frameworks stemming from the broader country NSPs. Kenya was the first African country to draft a KP-specific framework, although that was mostly geared toward service provision for sex workers. In 2017, South Africa launched the continent's first LGBTI framework. It identifies a core package of services for all KPs including peer-led outreach; clinic-based services; condoms and condom-compatible lube; HIV testing services; HIV, TB and STI prevention, care and treatment; SRH services; and laboratory services. Additional services tailored to each KP are identified. For MSM, these include pre-exposure prophylaxis (PrEP) and universal test and treat (UTT), rectal care and treatment, and screening for viral hepatitis. The LGBTI framework also highlights health worker training as a key component of MSM healthcare provision, although this is generally lacking in-country.

Most NSPs appear to promote the use of a human rights framework for working with KPs. While these frameworks remain a fundamental component of addressing the needs of MSM, they appear at odds with the restrictive legal frameworks adopted in these countries. Thus, with exception of South Africa, Kenya and Namibia, inclusion of MSM in NSPs remains largely tokenistic.

Implementation of NSP objectives may require persistent lobbying for MSM sexual health and HIV services and the leveraging of already existing, if somewhat hidden relationships, between providers of MSM services and key government allies. Given the increased funding and support in the context of KP programming and the 90-90-90 targets, a wide range of MSM services are being provided across the region. Table 3 provides a summary of policies across the region that could be used to support the implementation of further MSM sexual health and HIV services.

TABLE 3: POLICIES TO SUPPORT SEXUAL HEALTH AND HIV SERVICES FOR MSM IN SEVEN ESA COUNTRIES

Country	Policies
Kenya	• Kenya national AIDS strategic plan 2009/10-2012/13 • National guidelines HIV/STI programming with key populations • National AIDS Control Council strategic plan for 2015-2019 • Kenya HIV prevention revolution road map: Countdown to 2030
Malawi	• National HIV and AIDS Policy, 2013 • National HIV and AIDS Strategy 2015-2020
Mozambique	• National Strategic HIV and AIDS Response Plan 2010-2014
Namibia	• National strategic framework for HIV and AIDS response in Namibia 2010/11-2015/16
South Africa	• National LGBTI HIV Framework, 2017-2022
Uganda	• Uganda AIDS Commission includes MSM in HIV-AIDS strategic plan
Zambia	• National Health Strategic Plan 2011-2015 • National AIDS Strategic Framework 2017-2020

4. ROLE OF CIVIL SOCIETY ORGANISATIONS

National Strategic Plans provide only one indication of a state's commitment to sexual health and HIV services for MSM. In most countries, government strategies are augmented by the work of civil society organisations (CSOs). These CSOs provide advocacy, support and services tailored to MSM.

The role of CSOs has been acknowledged across all NSPs, albeit to varying degrees. In some cases, CSOs have been described as a critical resource in facilitating the empowerment of KPs. Acknowledging the value of CSOs in NSPs, however, does not always equate with a supportive environment for service delivery. Nevertheless, a number of initiatives including the International HIV/AIDS Alliance's SHARP programme and its successors point to possibilities for operationalising NSPs priorities, such as engaging MSM in sexual health and HIV services, even in hostile socio-legal environments.

Key findings from the SHARP programme demonstrate that it is possible to reach, engage, link and provide services to large numbers of MSM with HIV, health and legal concerns by supporting and working with CSOs in MSM communities. A particularly effective strategy for reaching MSM populations was through MSM-led and peer-driven outreach strategies. Using this approach appears to be effective for identifying and linking MSM to healthcare facilities for HIV testing and treatment as well as promoting ART adherence. The SHARP programme managed to reached a total of 14,900 MSM in the region with HIV and STI services. SHARP also reached 1,206 health care providers demonstrating that MSM CBOs can successfully engage, sensitise and partner with public health facilities.

One of the key findings in this study was the determining role of key allies within government in implementing and enhancing MSM related service delivery. The importance of key allies was equally applicable in more progressive contexts, such as Kenya, as well as in less inclusive environments such as in Malawi. Where contexts are hostile at a legislative or political level, these key allies work with CSOs to facilitate the roll-out of MSM services, as was evident at the Mulago Hospital in Kampala. In more progressive contexts, these key allies are the proactive drivers of KP-inclusive policy and implementation as is the case in Namibia, where there are strong and cordial relationships between officials in the Ministry of Health and CSO service providers for MSM.

5. REGIONAL OVERVIEW OF SERVICES

HIV and sexual health services for MSM are available in all the seven study countries, although mainly concentrated in the urban areas. The bulk of such services are currently provided by civil society organisations, as noted above. Table 1 below summarises the key service providers for MSM HIV and sexual health services in the seven country studies.

The availability of HIV services for MSM does vary widely from country to country – and over time.

As noted above, HIV and sexual health services are mainly provided by civil society organisations (CSOs), often in partnership with government. However, in many of the study countries, CSOs conducting MSM service delivery cannot legally register as non-governmental organisations. Often MSM services must be disguised as broader health services in order to not raise suspicion in contexts where homosexuality is severely stigmatised and/or criminalised.

In addition to the broader socio-political and legal contexts, a key determinant in the roll-out of comprehensive MSM sexual health and HIV services is the availability of health workers who have been trained - in both sensitivity and clinical competency - to treat MSM patients. This limits the ability of the public sector to provide appropriate services for MSM, even in cases where there is the political will to do so.

Across the region, MSM specific pre-service and in-service training has not been standardised and when training does occur it is often on an ad hoc basis and generally provided by CSOs. To a limited extent, sexual orientation and gender identity, or broader KP modules including MSM, have been integrated into pre-service training in South African, Malawian and Swaziland medical schools.

TABLE 4: KEY ORGANISATIONS PROVIDING MSM-FRIENDLY SERVICES, SEVEN COUNTRIES

Country	Organisation/Healthcare facility
Kenya	ISHTAR
	MAAYGO
	KANCO
	NYARWEK
	Institute of Tropical and Infectious Diseases
	HOYMAS
	SWOP
	GALCK
	Ukweli Mombasa
	G-Kenya Trust
	PEMA Kenya
	NRHS

Malawi	Bwaila Referral Hospital – STI Department Christian Health Association of Malawi – various church owned health care facilities CEDEP MANERELA+ Peace and Justice Support Network (PEJUSUN
Mozambique	Brigade mobile clinics AMODEFA LAMBDA
Namibia	Namibian Planned Parenthood Association OutRight Namibia Walvis Bay Corridor Group The Society for Family Health - Namibia
South Africa	Health4Men Clinics OutWellbeing Clinics Department of Health Clinics (n=200<) visit http://www.anovahealth.co.za/ to search for a sensitised healthcare facility
Uganda	MARPI Clinics at national referral hospitals, particularly: Mulago Hospital Mbale Referral Hospital Kisugu Health Clinic Kireka SDA Kiswa Health Centre Reproductive Health Uganda Bwaise Ice breakers Uganda clinic Reach Out Mbuya Parish HIV/AIDS Initiative TASO-Mulago AIDS Information Centre (AIC) Naguru Hospital Komamboga Health Centre Kitebi Health Centre Kawala Health Centre Kawempe Health Centre Spectrum Uganda (SMUG)
Zambia	Planned Parent Hood Association Railway Clinic Open Doors Project Friends of Rainka Chelstone Clinic Chreso Clinic

6. SNAPSHOT OF MSM SERVICES IN THE SEVEN STUDY COUNTRIES

6.1 Kenya

As noted above, same-sex activity is criminalised by the Kenyan penal code and stigma and discrimination against MSM is widespread, which creates barriers to accessing healthcare services and increases MSM vulnerability to negative health outcomes.

Despite this situation, Kenya's National HIV Strategic Plan includes MSM as a key population (KP). The Kenyan National AIDS Council (NASCOP) and their key population technical working groups (KP TWC) are key institutions that are driving HIV policy and programming in the region. Environmental and service provision improvements for MSM in Kenya demonstrate the catalytic role that research plays in changing policy.

In 2008, planning for the KP programme began in consultation between government, donors, research institutions, NGOs and KP organisations. Kenya developed and launched the continent's first KP policy in 2010.

Kenya was also the first African country to begin demonstration projects on pre-exposure prophylaxis (PrEP) for KPs. To date, integration of health worker competency and sensitivity training for service provision

to MSM has been slow, as has PrEP uptake by MSM. However, increasing MSM service provision in Kenya provides a good model for other countries in the region that are gradually improving their environments and services for MSM and other KPs.

6.2 Malawi

Many of the challenges experienced by MSM in Malawi are determined by prevailing social, religious and cultural norms that influence public discourse, laws, policies and practices. In recent years, state oppression and police brutality have contributed strongly to increasing homophobia.

In terms of healthcare provision, the primary healthcare system is generally poorly-resourced. The National HIV and AIDS Policy (2013) indicates the need to prevent and eliminate stigma and discrimination against vulnerable populations. However, criminalisation of homosexual acts has stemmed the development of more inclusive healthcare policy and provision of services. The national HIV/AIDS strategy emphasises the importance of safeguarding human rights in HIV/AIDS service provision and of creating welcoming environments free of stigma. Along with the National AIDS Commission, a key ally in this work is the Malawi Network of Religious Leaders Living with HIV and AIDS (MANERELA+), which is a membership network of religious leaders affected by HIV/AIDS. Its work focuses on reducing stigma, silence, denial, discrimination, inaction and mis-action in religious communities in Malawi. Other CSOs, such as CEDEP, are fundamental in delivering HIV services to MSM.

Healthcare providers often have low level knowledge and skill in relation to MSM and other KP in Malawi. However, pre-service training has begun to be integrated at tertiary level at the College of Medicine.

6.3 Mozambique

Mozambican society appears to be more tolerant than others in the region and public discourse on MSM is generally more accepting. Homosexuality was decriminalised in 2006. However, substantial gaps exist in terms of competent and tailored health-care provision for MSM.

Nonetheless, sexual health and HIV service provision for MSM have been steadily increasing since the country's decriminalisation of homosexuality in 2006. LAMBDA is currently Mozambique's only LGBTI organisation and remains instrumental in lobbying for affirming policy changes to improve service provision and the social environment for MSM. HIV service provision for MSM has been rolled out in conjunction with programmes focused on KPs. A mobile clinic model accessing so-called MSM hotspots, including taverns and clubs, has been employed in an effort to increase the use of sexual health and HIV services among MSM. These services are being provided collaboratively by LAMBDA and the Mozambican Association for Family Development (AMODEFA) and are supported by the national Department of Health, and international donors.

6.4 Namibia

In Namibia a broad KP focus at policy level in recent years has led to an increased awareness of the healthcare needs of MSM, with the health sector making provision for MSM and KP service delivery. Although MSM continue to experience high levels of marginalisation and social exclusion, a national household survey conducted by the Office of the Ombudsman (2013) reported that 73% of respondents felt that people with a different sexual orientation have equal rights in Namibia.

The lack of hostile legislation in Namibia assists in creating a more enabling environment for realising commitments to MSM service delivery that are made in the National HIV Strategic Plan. However, discriminatory attitudes towards MSM in health facilities prevail. In one study approximately 20% of MSM avoided healthcare services because of possible negative responses and a further 8% reported being denied services because of homophobia. Experiences of healthcare homophobia included verbal abuse from medical professionals and concerns regarding confidentiality.

Despite this situation, progress is evident in the health and rights literacy of the MSM population, where information and education initiatives have impacted positively. In addition, key KP allies in government have been instrumental in moving the KP agenda forward.

6.5 South Africa

South Africa is often cited as an example of good practice in the mainstreaming of MSM sexual health and HIV services across sectors, given its enabling constitutional and policy context.

In recent years sexual health and HIV service provision for MSM has been steadily increasing. Research to support MSM sexual health and HIV service provision has been predominantly located in metropolitan areas such as Johannesburg, Pretoria, Cape Town and Durban. However, there has been a recent shift toward increasing this research in more rural areas to ensure that MSM in these areas also benefit from the opportunities provided as MSM sexual health and HIV services advance. Recent research indicates that there may be significant differences between MSM in urban areas and MSM in rural areas.

South Africa was the second country in the region to adopt PrEP as an HIV prevention strategy in 2016. The availability of PreP has increased and is now available on request from public and private health care providers. However, uptake of PrEP among MSM appears to be low and more research to identify the barriers preventing uptake is required. Pre-service training on MSM for health workers, within broader sexual orientation and gender identity training modules, are increasingly being introduced at schools of medicine. In-service training is often provided by CSOs and NGOs. For example, ANOVA's Health4Men initiative and Yellow Dot Doctor campaigns have trained over 200 primary healthcare facilities with almost 4,000 public and private healthcare providers to provide MSM-friendly services.

6.6 Uganda

In recent years, Uganda experienced the introduction and passing in parliament of the Anti-Homosexuality Bill which led to clampdown and suppression of MSM. The subsequent annulling of the Anti-Homosexuality Act has led to the (re)creation of some spaces for the emergence of LGBTI presence and voice in Ugandan society. This has included the mainstreaming of MSM healthcare provision into public health services.

HIV services for MSM have expanded in very recent years. There are a number of reasons for this: international donor influence, in-country advocacy by queer CSOs, and other regional level shifts.

One salient characteristic of the Ugandan context is the mainstreaming of MSM services in broader most-at-risk population (MARP) programming at a national level. This has led to increased pre-service and in-service training for health workers. Healthcare facilities which have been sensitised, such as Mulago Hospital in Kampala have reported an increased uptake of MSM sexual health and HIV services.

6.7 Zambia

In Zambia there has been substantial upscaling of HIV/AIDS treatment, care and prevention in recent years. While there are global commitments in terms of funding and implementation, including for MSM, these are generally inadequate to meet the needs of MSM who still struggle to access basic health services such as HIV counselling and testing (HCT), condoms and lubricant.

The hostile legislative environment makes it difficult to address the needs of MSM comprehensively. In the past, efforts by the National AIDS Council to roll out interventions with KPs have been hampered by the legislative context. Nevertheless, a range of frameworks focus on the healthcare needs of MSM. These include the UNAIDS's Investment Framework, The Global Fund's 2012-2016 Strategy Framework, as well as the President's Emergency Plan for AIDS Relief (PEPFAR) Blueprint for Creating an AIDS-Free Generation. The recent NSP (2011-2015) also included MSM as a high-risk population, though without the necessary programming to target these populations.

National PrEP roll-out is scheduled following the completion of demonstration projects at selected healthcare facilities. There has also been an increased availability of information, education and communication material on sexual health and HIV prevention for MSM at healthcare facilities. In-service training on MSM within broader KP modules for healthcare providers is increasing at university teaching hospitals and state healthcare facilities.

7. CONCLUSION

While MSM continue to experience severe human rights violations and may live in extremely hostile contexts, there are also signs of possible shifts across ESA towards a greater understanding and acceptance. These shifts in social, political and cultural climate are important because they are the broader determinants of the roll-out of competent, professional and tailored MSM health services.

The concerted KP focus in recent years has created a situation in which MSM service provision is a stated goal of NSPs across the region and it has become increasingly common for governments to partner with CSOs to achieve this. However, given the vagaries of societal attitudes and the often-changing political climate in relation to MSM, the adequacy of MSM healthcare services changes both from country to country and over time.

Overall this situational analysis found the key stakeholders across the region, including CSOs in partnership with governments, can and do provide tailored health services to MSM populations despite constraints.

8. REFERENCES

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