The challenges to antiretroviral adherence among MSM and LGBTI living with HIV in Nairobi, Kenya

A qualitative study

A HEARD programme of work on HIV, Human Rights and Social Justice
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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
amfAR	American Foundation for AIDS Research
ART	Antiretroviral therapy
ESA	East and southern Africa
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HOYMAS	Health Options for Young Men in HIV, AIDS and STIs
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
LVCT	Liverpool Voluntary Counselling and Testing Clinic
MSM	Men who have sex with men
MSW	Male sex workers
UN	United Nations
UNAIDS	The Joint United Nations Program on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation

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Summary

It is now possible for antiretroviral therapy (ART) to reduce viral load to the point where an infected person is no longer, or much less, infectious to others. As a result, 'treatment as prevention' has become the cornerstone of UNAIDS's post-2015 global strategy to end AIDS by 2030. As the expansion of treatment provision continues, and access improves, adherence becomes a determining factor in the impact of ART for both treatment and prevention. HEARD conducted exploratory research with a key population focus in the form of a small pilot study to augment the very limited existing research on challenges to ART adherence in men who have sex with men (MSM) and lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities living with HIV in east and southern Africa (ESA). This report presents the pilot study's indicative evidence that the types of challenges experienced by MSM and LGBTI do not differ significantly to those experienced by the general population. However, indications do suggest MSM and LGBTI experience these challenges more often, acutely, and with less opportunity to overcome them. Within the constraints of this pilot, results recommend addressing the challenges to ART adherence for MSM and LGBTI from a human rights approach of decriminalisation and reducing stigma and discrimination in society. This paper provides an imperative and direction for further research to take forward the provisional findings of this pilot study.

Introduction

The challenges to antiretroviral therapy (ART) adherence are the subject of an emerging body of research and interest, and the need to focus on key populations in health systems is well known. This report presents HEARD's exploratory research into challenges to ART adherence amongst the men who have sex with men (MSM) and lesbian, gay, bi-sexual, transgender, intersex (LGBTI) key populations in Nairobi, Kenya. The dearth of research that combines a focus on ART adherence with key populations living in the east and southern Africa (ESA) region was revealed by a systematic literature review carried out by HEARD. The knowledge gap provided impetus for exploratory research in the form of the pilot study presented in this report. This study recorded perceptions of healthcare workers, key population programme officers, and MSM and activists living in Nairobi. The report primarily finds that challenges to ART adherence experienced by HIV-positive MSM and LGBTI are not unique to MSM and LGBTI, but are more acute and prevalent within the MSM and LGBTI communities. The paucity of existing research and the limitations of the pilot study constrain the validity with which key variables can be identified without further research. Initial indications, though, suggest criminalisation, discrimination, and (double) stigma may affect the comparative severity of many challenges to ART adherence for MSM and LGBTI that are otherwise shared with the general population, and pursuant research should be undertaken.

The United Nations holds that criminalisation, discrimination, and stigma in society against key populations create barriers to realising their human right to the highest attainable standard of health (UNFPA, MSMGF, and UNDP *et al* 2015: 7). Further, on 29 September 2015, 12 UN entities (ILO, OHCHR, UNAIDS Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP and WHO) released 'an unprecedented joint statement' within which is agreed a 'failure to uphold the human rights of LGBTI people…have a far-reaching impact on society – contributing to increased vulnerability to ill health including HIV infection' (UN 2015: 1). Research that approaches the challenges to ART adherence for HIV-positive MSM and LGBTI within a human rights framework and uses human rights language, may engage more meaningfully with what could form the key contextual variables, although further research is required to confirm the nature of these. This will contribute to the sound evidence base needed to inform interventions and programmes in how to effectively promote ART adherence among key populations through strategies to reduce and overcome underlying causes driving challenges to adherence

Background

The ESA region bears the greatest burden of the global HIV and AIDS epidemic. With only 5% of the world's population, ESA is home to half the world's population living with HIV. Today the region continues to be the epicentre of the HIV and AIDS epidemic, experiencing 48% of the world's new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths (UNAIDS 2013). From this crisis, countries in the region have emerged as some of the world's leading nations in HIV testing, up-scaling ART coverage, and increasing condom usage. The past five years or so have seen the rise of the 'HIV treatment as prevention'[1] approach, whereby treatment reduces viral load to the point where an infected person is much less infectious to others. Treatment as prevention is a core

[1] Antiretroviral therapy reduces the risk of HIV transmission by up to 96% (UNAIDS 2014a)

component of the post-2015 UNAIDS global Fast-Track strategy to end AIDS as a public health concern by 2030. The strategy aims by 2020 to have 90% of all people living with HIV to know their HIV status; 90% of all people with diagnosed HIV infection receiving sustained ART, and; 90% of all people receiving ART to have viral suppression. These targets rise to 95% by 2030 (UNAIDS 2014b).

As access to ART scale-up continues to be at the forefront of programme efforts to prevent new infections and HIV progression, socio-behavioural factors that may affect the adherence of ART become increasingly salient (Cock 2009: 488). For viral suppression, evidence shows optimal adherence to ART is >95%[2] with studies suggesting that inadequate adherence in resource-poor countries averages 23%, varying considerably by context (Paterson, Swindells, Mohr *et al* 2000; Scanlon and Vreeman 2013: 4). This has led to an exploration in research of the challenges to adherence for PLHIV on ART in the general population within ESA, but, as yet, there has been extremely limited focus on key populations like MSM and LGBTI: '[r]esearch to improve access and adherence among these [key] populations is virtually non-existent in LMIC' (Scanlon and Vreeman 2013: 7).

A paucity of research on key populations is problematic because MSM, LGBTI communities, and key populations more generally experience comparatively higher rates of HIV prevalence – up to 19 times greater globally in MSM than for the general population (UNAIDS 2014c: 20). Key populations also typically suffer human rights infringements that undermine their access to, and engagement with, HIV prevention and treatment information and services. Key populations such as MSM and LGBTI are defined as disproportionately affected by HIV in all countries and settings.

The exclusive general population approach to researching and promoting ART adherence repeats similar knowledge gaps of earlier HIV prevention research (UNAIDS 2010: 3; Beyrer, Wirtz, and Walker *et al* 2011: 8). Methodologically, it can be comparatively challenging to research populations that are criminalised, discriminated against and stigmatised in society due to the safety considerations for study participants, the hidden nature of these populations, and a lack of dedicated funding (Beyrer, Wirtz, and Walker *et al* 2011: xxi). These attributes that hinder research on key populations also form the impetus for a focus in understanding and addressing challenges these populations may be facing in ART adherence given their vulnerability. A researched evidence base to advocate and inform from is a prerequisite for more sensitised programmes and interventions. Continuing to orientate research at the general population level will result in a lower return on investment in health outcomes (WHO 2014: 7-8). Furthermore, the human right to the highest attainable standard of health will continue to be beyond the reach of key populations, such as MSM and LGBTI that form the focus of this paper. Directions for further research were provided by MSM and LGBTI community activists who attended an amfAR-organised one and a half day meeting to develop an LGBTI research agenda, in partnership with the Gay and Lesbian Coalition of Kenya and the International AIDS Vaccine Initiative (amfAR 2014). This community-owned research agenda is where the guiding question of this report, and the pilot study it represents, and the associated literature review is derived.

[2] Although >95% adherence is still cited for optimal adherence, more recently research has emerged suggesting lower adherence is required for effective viral suppression using more potent boosted protease inhibitors and nonnucleoside reverse transcriptase inhibitors. Until there is a consensus on optimal adherence to achieve viral suppression and avoid developing resistance, caution is exercised by using the >95% figure for optimal adherence (Kobin, and Sheth 2011: 373; Mitiku, Abdosh, and Teklemariam 2013)

Methodology

Overview

This pilot study was informed by a systematic literature review (HEARD 2015) that revealed a large knowledge gap on the challenges to ART adherence among HIV-positive MSM and HIV-positive members of the LGBTI communities in ESA. The review found just two studies contributing to research in this area.

The first study examined within the literature review summarised challenges to ART adherence unique to HIV positive transgender people but lacked empirical data on comparative rates of ART adherence (Schneiders 2014: 28-9). The second study established an empirical basis, within a limited sample size, for a worse rate of ART adherence among MSM compared to other high risk adults but remained inconclusive as to why (Graham, Mugo, and Gichuru *et al* 2013: 1255-65). The scarcity and limitations of the studies examined in the literature review contributed to an impetus for HEARD to undertake the exploratory research presented in this report. The pilot study undertaken consisted of key informant semi-structured interviews, over a period of two weeks, recording perceptions of challenges to ART adherence amongst sensitised and unsensitised HIV healthcare workers, key population programme officers, and MSM activists living in Nairobi, Kenya.

Country case study selection

Kenya was selected due to the nation's decision to focus resources on dramatically up-scaling ART coverage, attributed with stabilising prevalence at around 7% in 2003 from a peak of 10.5% in 1995-6, with a trend of reduction to 5.6% reported in 2012 (National AIDS Control Council 2014: 3). What makes the Kenyan context particularly relevant is that, whilst the general population has a stabilised prevalence at around 5.6%, key populations continue to experience a comparatively elevated prevalence of HIV without signs of significant reductions. Estimated HIV prevalence is 29.3% for female sex workers, 18.2% for MSM, and 18% for people who inject with drugs (National AIDS Control Council 2014: 16, 18). As mentioned in the background of this report, a wider context of criminalisation, discrimination and stigma is associated with worse HIV, AIDS and health outcomes for key populations. In Kenya homosexuality is illegal and punishable by custodial sentence, although the application of charges is rare. This policy environment reflects norms across the Anglophone ESA region (except South Africa), where anti-homosexuality legislation is typically inherited from British colonial law. Kenya also follows the regional norm with high levels of societal stigma and discrimination directed to men perceived to be engaging in sex with other men, with recent eruptions of violent mob attacks and police harassment in the coastal counties of Kilifi, Mombasa, and Kwale. Human Rights Watch released a report on 28 September 2015 indicating 'The Kwale violence and subsequent displacement of MSM and trans women negatively impacted HIV prevention and treatment efforts. Evans Gichuru of the Kenya Medical Research Institute (KEMRI) expressed concern that "people on medicine [ART] can't get medicine" if they are in hiding' (Human Rights Watch and PEMA 2015: 15, 24). Contrary to what may be expected in such a context, the report also highlights 'the organized and outspoken movement in support of human rights for LGBTI people' (Human Rights Watch and PEMA 2015: 9). Civil Society Organisations (CSOs) are valuable stakeholders for accessing and providing insights into underground or hard to reach populations such as MSM who are criminalised and stigmatised in Kenya. Due to a concentration of CSOs and HIV

treatment clinics for MSM and LGBTI located in Nairobi, this city was selected as the site for the pilot study.

Key informant selection

Once the HEARD researcher arrived in Nairobi, Kenya, securing initial interviews was done directly with CSOs, clinics, and individuals through email, telephone, social media, and face to face at a LGBTI book launch event. Initial interviews led to recommendations for other CSOs and clinics to interview (snowball sampling method). Clinics were targeted that provide HIV voluntary counselling and testing (VCT[3]), and treatment.

Study participants

Participating organisation/individual(s)	Participant description	Interview date
Coptic Hope Clinic VCT, Nairobi • Programme Manager	STI, VCT and ART clinic with all HIV-related services free to the public	27.08.2015
HOYMAS, Nairobi • Two VCT Counsellors • Clinical Officer	STI, VCT and ART clinic specialised in advice and support services for MSM and MSWs	25.08.2015 (spanning two interviews)
ISHTAR, Nairobi • Programme Manager • HTC nurse	STI, VCT and clinic specialised in advice, programmes and advocacy for MSM and MSW rights	19.08.2015
LGBTI activist and journalist, Nairobi	Kenyan individual operating in advocacy for MSM rights, met at *Boldly Queer: African Perspectives on Same-Sex Sexuality and Gender Diversity* book launch	20.08.2015
LVCT Health, Nairobi • Key Populations Programme Manager • Programme Officer (and counsellor)	STI, VCT and ART clinic specialised in service delivery and support to key populations with all HIV-related services free to the public	27.08.2015
Three MSM individuals	Contact made and interviews conducted via snowball sampling from earlier interviews	Not disclosed to preserve anonymity

Data capture and processing

In-depth semi-structured face to face key informant interviews were conducted that endured between one and a half to two hours in length. Interviews were with individuals except for three interviews where participants indicated preference to be interviewed together. Notes of themes were made during the interview, but interviews were recorded using a Dictaphone and transcribed after. Once transcribed, all recordings were deleted, as per respondents' wishes. Notes and transcriptions were scanned for common themes, especially relating to challenges to ART adherence. As this was a small pilot study, it was not necessary to code or tabulate transcriptions to deduce common themes.

[3] Some respondents termed this HIV counselling and treatment (HCT)

Study limitations

As a small-scale pilot study, findings are indicative only, primarily intended to guide any further undertaking of research. Due to the singularity of context, it is not possible to make regional assertions based on the pilot study, due to differences that include, but are not limited to: rural/urban settings, political context, legal environment, national/local policies and programmes, civil society presence, stigma and discrimination, and quality/coverage of health care services.

Findings

Summary of key challenges (In order of frequency reported)

Challenge	Description	Reporting rate and origin
Pill-taking during social occasions,	Delaying/missing doses to reduce visibility of ART pill-taking so as to maintain HIV non-disclosure, as HIV disclosure is feared to lead to sexuality disclosure	All three clinics able to prescribe ART medication and the VCT clinic that were interviewed reported this challenge
Inadequate access to food	Some ARVs must be taken with or after food consumption to support drug absorption to required levels. Doses can be delayed/ missed until people can afford food with which to take the pills	All three clinics able to prescribe ART medication that were interviewed reported this challenge
Unsuitable living arrangements	Difficulties associated with physically storing the pills where they will not be found revealing HIV status. This includes storing them at a friend's home where access could be an issue	Two out of three clinics able to prescribe ART medication and the VCT clinic that were interviewed reported this challenge
Fear and experienced stigma from service providers	Both the fear and the lived experience of stigma from healthcare workers on the basis of perceived sexuality breaks down trust relationship between health provider and patient	Two out of three clinics able to prescribe ART medication, the VCT clinic, and the LGBTI activist that were interviewed reported this challenge
Concerns of non-confidentiality of service providers	Fears their perceived sexuality and HIV status will be disclosed by health workers to other health workers, the local community and/or Government and that persecution or prosecution will follow	Two out of three clinics able to prescribe ART medication, the VCT clinic, and the LGBTI activist that were interviewed reported this challenge
Fear of ART side effects	Fears of very negative, persistent side effects of ART is often based on rumours and can lead to delay of treatment	Two out of three clinics able to prescribe ART medication that were interviewed reported this challenge
Alcohol and drug abuse	Drugs and alcohol use is reportedly to deal with stigma and vulnerability but abuse of drugs and alcohol can lead to depression and other mental disorders that can interfere with adherence	One out of three clinics able to prescribe ART medication and the VCT clinic that were interviewed reported this challenge
Lack of transport to clinics	Poverty creates a barrier to public transport costs to collect ART pills monthly for those living far away	One out of three clinics able to prescribe ART medication that were interviewed reported this challenge

Pill burden	The number of pills (especially on second line regimes) present a challenge for some people to physically swallow	One out of three clinics able to prescribe ART medication that were interviewed reported this challenge

Discussion of key challenges

This discussion draws primarily on data from the pilot study conducted in Nairobi, supplemented with information generated by the systematic literature review (HEARD 2015).

MSM-specific challenges and criminalisation

One of the most commonly reported challenges that more specifically applies to MSM is the concerns and perceptions from MSM that healthcare workers will either discriminate against them on the basis of their sexuality or disclose their sexuality to people in the MSM's community. The pilot study documented some personal accounts of discrimination: 'I went to Kenyatta hospital. It materialized during the consult how I thought I might have got the [HIV] infection. Her attitude was totally different. She didn't like it. She said "you kids of nowadays"' (MSM, Nairobi). Stigmatising attitudes do not seem to be isolated incidents: 'I think it is still widespread. We did a programme to sensitise healthcare workers who were going to research MSM. But still they had an attitude problem' (Programme manager, ISHTAR). Associated fears of discrimination and breach of confidentiality may be linked to the political intolerance of MSM and LGBTI: 'I had a friend who last week said to me how can we trust the system with our deputy-president saying what he has about gay people? He might just pay someone and expose all these people, their results and sexuality… I think there is a lot of paranoia and it's not healthy' (MSM, Nairobi). Kenya's hostile legal environment, which criminalises homosexuality with up to 14 years in prison, could deepen the impact of the political intolerance: 'MSM are very concerned about confidentiality of healthcare workers – this fear is worsened by criminalization.' (Programme Officer, LVCT). Although the general population would not experience this effect, other key populations may experience very similar challenges since criminalisation and stigma also occurs around sex work and injecting drugs, both of which also carry a high risk to HIV acquisition so have similar access needs to healthcare as MSM.

Strategies to mitigate and overcome challenges

A few strategies MSM use to mitigate or overcome this type of challenge were described in the interviews along with how some of these can impact on treatment. Some MSM attend general healthcare centres and simply do not disclose their sexuality to healthcare workers: 'Not all MSMs disclose they are MSM when they come to CHC. Sometimes that's better because they won't have the feeling that they are being stigmatized. They lie on the patient questionnaire. There are very few that are confident enough to disclose' (Programme manager, Coptic VCT). Fear of disclosure for MSM in general healthcare settings can mean not getting the help they need: 'MSM cannot disclose their status and some STIs like anal warts because this would reveal the MSM's sexuality' (Clinical Officer, HOYMAS). Building trust between patient and health care provider is key: 'Patients feel more comfortable over time, building a rapport with their health worker and open up more' (Programme Officer, LVCT). In Nairobi there are a number of VCT clinics that specialise in MSM where there may be less fear around disclosure: 'I like going somewhere like LVCT because I don't need to lie about [my sexuality] and can ask them to check everything. I get peace of mind from that. It didn't feel judgmental at all. I can just be myself' (MSM).

General challenges and double stigma

Very commonly reported challenges in this pilot study, such as access to food or pill taking during social occasions, are not exclusive to MSM or key populations. It was beyond the scope of this pilot study to determine definitively whether and to what degree MSM experience these challenges more commonly, acutely, or have the ability to mitigate or overcome them in Nairobi, Kenya. However, feedback during interviews did suggest circumstances specific to MSM may deepen these challenges to affect MSM disproportionately. For example, a clinic spoke about 'double stigma' – the interlinked stigmas of being MSM and living with HIV. There was a reported fear that HIV disclosure could lead to sexuality disclosure with associated discrimination, therefore a reluctance to take ART pills during social occasions could be greater for MSM. This was reported to be a particularly pertinent issue for bi-sexual men where the female partner is unaware the man also has sex with other men. An interesting case was described relating to the interplay of stigmas where a young MSM recently requested to be transferred from an MSM-specialised clinic to a clinic serving the general population because his mother wanted to accompany him to the clinic where he collected the ART pills. The young man had not disclosed his sexuality to his mother as he expected his mother's emotional support for his ART adherence to be withdrawn if she knew he was MSM as well as HIV-positive (Clinical Officer, HOYMAS).

The fear that disclosure of HIV status would lead to family and friends discovering their sexuality, also created challenges for storing ART medication 'out of sight' at home. This is particularly true for bi-sexual men who have unaware female partners. This leads some MSM and bi-sexual men to store ART pills at friends' homes but that can create access issues if the friend is not at home when the pills should be taken. Furthermore, the burden of this 'double stigma' was speculated in one interview as having negative effects on mental health and increased alcohol and drug use as coping mechanisms: 'I think it's greater for MSM. Alcohol and substance abuse as a way of releasing the stress. We just had one a month ago that committed suicide' (HTC nurse, ISHTAR). Further research is required to examine the relationship between HIV-related stigma and sexuality-related stigma, and the consequences of this 'double stigma' for ART adherence.

Male sex work

HOYMAS and LVCT clinics indicated significant levels of transactional sex in the MSM community with HOYMAS recording 37.5% MSM patients registering themselves as male sex workers (MSWs), and it was the interview participant's perception that self-reporting leads to under-reporting of the real prevalence of transactional sex work (Clinical Officer, HOYMAS, anonymised patient data March-July 2015). Under-reporting was attributed to the practice of non-cash transactions/favours for sex, blurring the lines between self-perceptions MSW and MSM identities (Programme Officer, LVCT; Clinical Officer, HOYMAS). A scan through relevant literature indicates further research in this area is required to accurately ascertain the extent to male sex work within MSM communities (Cáceres, Konda, and Segura *et al* 2008). The prevalence of sex work within the MSM community is important because MSWs may experience greater and different challenges to ART adherence than MSM who do not sell sex or engage in transactional sex due to overlapping vulnerabilities (WHO 2014: 6-7). MSWs may experience additional stigma resulting in: greater barriers to HIV disclosure by healthcare professionals; greater need for discreet ART medication storage, and; more common barriers to pill-taking during social/work events since they may also risk their livelihood if clients found out they were HIV-positive (Programme Officer, LVCT). An interviewee's perception was that alcohol and drug abuse is also higher amongst MSW as 'it's part of the "scene" and it bolsters confidence to approach and engage in sex with strangers' (Programme Officer, LVCT). It becomes clear that MSWs constitute a significant, though perhaps not distinct, sub-population of MSM communities that could have a skewing effect on records of ART adherence within the broader MSM population. The only study on

MSM discussed in the literature review (HEARD 2015) does record rates of transactional sex work for each sample population, but conflates MSW and MSM in the discussion of results.

Beyond MSM to LGBTI

The experience of interviewees was both personally and professionally largely limited to MSM which prevented interviews expanding beyond the lived experiences of MSM and male bisexuals to explore challenges experienced by lesbian, female bi-sexual, transgender, and intersex communities. The literature review suggests that challenges across these communities are diverse, with one study identifying challenges unique to HIV-positive transgender persons on ART such as drug interactions with hormone therapy. The ISHTAR programme manager stressed the need to close the wider knowledge gap that exists around distinct communities within the MSM and LGBTI key population umbrella: 'Lesbians have very different issues to MSM. We have brought it up at the policy level but [policy makers] say there is not enough data on lesbians on HIV, or bi[sexuals] or trans[gender]' (Programme manager, ISHTAR). The diversity in health needs is reinforced by a LGBTI activist interview participant: 'As a gay man my needs would be so different from a lesbian woman or a trans[gender] person. My needs are absolutely different. It's access to healthcare that's important' (LGBTI activist and journalist, Nairobi).

Concluding remarks

The results of the exploratory research presented in this report, and the associated systematic literature review, suggest that HIV-positive MSM may experience a higher burden of challenges to ART adherence. Although the majority of these challenges are also found among the general population, they may be less acute and less prevalent given overlapping vulnerabilities and double stigma experienced by MSM and explored in this report. Indeed, the key informant interviews held in Nairobi, Kenya begin to indicate the breadth and depth of perceived challenges to ART adherence among MSM that may begin to account for Graham, Mugo, and Gichuru's (2013) study finding poor ART adherence and health outcomes among MSM in coastal Kenya compared to other high-risk groups (HEARD 2015).

The pilot study, and the literature review preceding it, present a case for a commitment to further, human rights-framed, research into ART adherence among MSM and LGBTI living in the ESA region. Research to close the knowledge gap around the challenges to adherence to ART amongst HIV-positive MSM and LGBTI communities within ESA is essential to inform appropriate resource allocation, programme design, and targeted interventions to reduce and overcome challenges to MSM and LGBTI fulfilling their human right to the highest attainable standard of health.

Recommendations for further research

- Further research is needed to build on this pilot study to better understand the linkages between criminalisation, discrimination, and stigma directed towards (HIV-positive) MSM and LGBTI communities, on the one hand, and greater challenges to ART adherence, on the other.

- 'Double stigma' was a recurring theme of the pilot study. This term describes how a combination of stigmas can interact to exponential negative effect. Further research should examine the relationship between HIV-related stigma and sexuality-related stigma, and the consequences of this 'double stigma' for ART adherence may

- Despite criminalisation, discrimination, and (double) stigma, Nairobi (and other cities in Kenya) boast dedicated HIV VCT and treatment centres for MSM (and LGBTI). It could be impactful in guiding future interventions to research the degree to which dedicated services operating within an environment of hostility may mitigate against the harmful effects of criminalisation, discrimination, and (double) stigma on the HIV outcomes of MSM and LGBTI.

- Indicative findings of the pilot study indicate a higher proportion of sex work and drug (and alcohol) abuse amongst MSM, than the general population. Overlapping vulnerabilities resulting from multiple high risk behaviours should be researched with an aim of nuancing identities, analysing the effect of intersecting identities and forming a more accurate association of health outcomes with these specific behaviour characteristics. The health outcomes of MSWs may currently be conflated into MSM for instance.

- Both the literature review and the pilot study reveal that the narrative of both research and service provision is dominated by MSM, largely to the exclusion of lesbians, (particularly female) bisexuals, transgender and intersex people. The perceptions from the pilot study also suggest MSWs are a significant sub-population within the MSM community, possibly distorting research and intervention results if they are conflated. Therefore, further research is required to investigate the sometimes indistinct and overlapping identities (and vulnerabilities) of MSM and the sub-population of MSW, and lesbians, gay, (particularly female) bisexuals, transgender and intersex people to better delineate what challenges to ART adherence are particular to each.

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Glossary

Antiretroviral therapy or antiretroviral treatment (ART) refers to a triple or more antiretroviral drug combination.

Lesbian is a woman who is sexually attracted to another woman/other women.

Bisexual is used to describe a person who is physically, romantically, and emotionally attracted to men and women.

Discrimination When stigma is acted upon, the result is discrimination that may take the form of actions or omissions. Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures.

Gay The term 'gay' can refer to same-sex sexual attraction, same-sex sexual behaviour, and same-sex cultural identity. In accordance with UNAIDS 2011 terminology guidelines, 'men who have sex with men' has been the preferred term throughout this report.

Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body, and other expressions of gender, including dress, speech and mannerisms.

Homophobia is fear, rejection, or aversion, often in the form of stigmatising attitudes or discriminatory behaviour, towards homosexuals and/or homosexuality.

HIV-positive A person who is HIV-positive has had antibodies against HIV detected on a blood test or gingival exudate test (commonly known as a saliva test). Synonym: seropositive.

Human immunodeficiency virus (HIV) is the virus that weakens the immune system, ultimately leading to AIDS. Since HIV means human immunodeficiency virus, it is redundant to refer to the 'HIV virus'.

Intersex An intersex person is an individual with both male and female biological attributes (primary and secondary sexual characteristics).

LGBTI is used in preference to 'homosexuals' as this term tends to make lesbians invisible, does not encompass bisexuals and transgender people and may be considered offensive by many gays and lesbians.

Men who have sex with men (MSM) MSM is an abbreviation used for 'men who have sex with men' or 'males who have sex with males'. The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.

People living with HIV (PLHIV) reflects the fact that an infected person may continue to live well and productively for many years.

Prevalence Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who are living with HIV at a specific point in time.

Sexual orientation refers to a person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender, or more than one gender.

Stigma and discrimination 'Stigma' is derived from the Greek meaning a mark or a stain. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy.

Transgender is an umbrella term for all people whose internal sense of their gender (their gender identity) is different from the biological sex they were assigned at birth. Transgender does not imply any specific form of sexual orientation and may include transsexuals and cross-dressers. They could identify as female-to-male or male-to-female, and may or may not have undergone surgery and/or hormonal therapy.

Photograph of 'VCT': sign painted in a stairwell to a discreet clinic for sexual and reproductive health services, Pangani, Nairobi, Kenya © HEARD/UKZN

About HEARD

HEARD is a leading applied research centre with a global reputation for its research, education programmes, technical services, partnerships and networks, devoted to addressing the broad health challenges of Africa. HEARD's aim is to shape public health policy and practice in order to reduce health inequalities in Africa and to improve the reach, comprehensiveness and quality of health services delivery throughout the region. HEARD's work entails catalysing, conducting and disseminating innovative research on the socio-economic aspects of public health, especially the African HIV and AIDS pandemic. HEARD was established in 1998 and is based at the University of KwaZulu-Natal, South Africa.

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