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OUT

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Lessons Learned

Uptake of Post-Exposure Prophylaxis (PEP) by Men who have Sex with Men in Tshwane (Pretoria).

SUMMARY

The activity that OUT is focussing on, is the provision of bio-medical services to gay men and men who have sex with men (MSM) in Tshwane (Pretoria), with the specific focus for this Lessons Learned Document, on providing Post-Exposure Prophylaxis (PEP) at the OUT Clinic and at other mobile sites, such as sex clubs, as well as at mobile events, such as Gay Pride. This activity aimed to achieve the target of reaching 33 clients, provided with PEP medication, for the period January 2014 till June 2014. OUT learned that the uptake of PEP medication remained low, despite implementing all the activities as planned. With this Lessons Learned Document, OUT will seek to learn why the uptake remained low.

DESCRIPTION OF ACTIVITY

With the support of the Aids Fonds and COC, OUT implemented a 3 year programme to promote bio-medical prevention methods among gay men and other Men who have Sex with Men (MSM) in Tshwane (Pretoria). The activity that OUT is focussing on for this Lessons Learned Document, is the provision of Post-Exposure Prophylaxis (PEP), as prevention method, at the OUT Clinic and at other mobile sites, such as sex clubs, as well as at mobile events, such as Gay Pride. PEP Treatment was provided free of charge.

The Programme consisted of the following activities:

- Monthly themed posters which were put-up at gay venues.
- Monthly SMS's on bio-medical prevention to 1067 people.
- Monthly electronic newsletters to 3370 people.
- Other ad-hoc activities such as polls and articles in the gay press.
- A prevention website (www.men2men.co.za) and links to this site through sms's and newsletters.

Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally, or through sexual intercourse. It should be taken immediately (within 72 hours) after being exposed.

Post-Exposure Prophylaxis is currently the only way of reducing the risk of development of HIV infection in an individual who has been exposed to the virus, and as such, is widely considered to be an integral part of the overall strategy for preventing the transmission of HIV[i].

The prevalence of HIV infection among gay men and MSM in South Africa, is high, as established by several research studies. According to the JEMs Study the prevalence in South Africa, is 38,3 % (and can be as high as 47%)[ii]. PEP treatment can reduce the risk of HIV infection by over 80%, according to the World Health Organisation (WHO) [iii]. Since 2005, the US Centres for Disease Control and Prevention (CDC) has recommended the use of PEP to prevent HIV transmission after possible exposure[iv].

Although the above is widely accepted, the South African Government still does not provide PEP treatment at Government Health Facilities. Clients can, however, access this treatment via their General Practitioner (medical doctor or GP), by getting a prescription and paying for the medication.

Since PEP treatment is thus still not accessible to the majority of the vulnerable Key Population, that OUT serves; and it is seen as an effective prevention method for preventing the spread of HIV, OUT chose to include this activity in their over-all Proudly Combined Program.

OUT wanted to create greater awareness and increase knowledge of PEP Treatment among its Target Population.

The Programme conducted two online surveys to determine the target population's awareness and knowledge of PEP Treatment. In the 2011 survey (208 respondents), more than 50% of respondents indicated that they never heard of PEP before and did not know where to access it. According to the 2012 survey (81 respondents), it was almost 75% of respondents who gave the same indication.

Despite of the extensive marketing over a substantial period of time, as well as no costs barriers, the uptake of PEP remained very low with not more than 2-3 clients per month.

The problem that OUT wished to address through this lessons learned documentation activity, was the fact that PEP treatment is still not widely accessible to the majority of gay men and MSM.

The objective was to make PEP treatment accessible to the above target population, and to create more awareness for this prevention method, as well as increase knowledge about it.

The context of the target population varies from young (18-25 year old), black, under-resourced (financially and educationally) MSM from the township- and rural areas; to the older (25-50 year old), black and white, resourced (low-to-middle income and educated) MSM from the city areas.

This activity was part of the Proudly Combined Program spanning from 2011-2014, and activities included an on-site Health Clinic, where bio-medical services are offered free of charge; an active marketing campaign to market these services through the gay media, monthly electronic newsletters, and an updated website; and a Peer Outreach Program, where trained peer educators reach out to the under-resourced MSM in their communities.

IMPLEMENTATION AND ACHIEVEMENTS

Steps included:

a) Procure funding (proposal and application submitted for funding) for PEP treatment and salary for full-time nurse

b) Secure a full-time registered nurse (trained and experienced in working with MSM)

c) Secure a kitted clinic (venue and medical equipment)

d) Develop and print BCC material (PEP pamphlet and posters)

e) Market services through word-of-mouth, gay media (newspaper and electronic media), social media (Facebook, Twitter), mainstream press (newspapers), posters (distributed through OUT's network), press releases, articles, monthly electronic newsletters, pamphlets (distributed through OUT's network), OUT's website, M2M website, banner, visibility at Pride and other events, Peer Outreach Program (peer educators educating MSM through face-to-face and event outreach activities)

f) Attend mobile events (Gay Pride)

g) Regular HCT at sex club (Camp David), where PEP banner is displayed

The approach was to make direct services (on-site clinic, open weekdays) available and accessible to the target population, as well as face-to-face outreach (peer educators). Marketing was done. Service was offered free of charge.

OUT's thinking and assumptions were that the availability and accessibility of PEP treatment would lead to a high uptake in numbers.

A further assumption was that the amount of marketing strategies would be sufficient in educating MSM about the benefits of PEP treatment, and that it would lead to large numbers of MSM accessing PEP treatment. OUT also assumed that all the above strategies, combined with the National HIV Campaign, would lead to change in the risky sexual behaviour that many MSM engage in (prevention is better than cure).

Resources needed were:

a) Financial resources: Funding was secured to cover the salary of the registered nurse, equipment for the clinic (if and where needed), and for the PEP Treatment (medication).

b) Human resources: A registered nurse was needed, a marketing consultant, a project co-ordinator, as well as peer educators.

c) Competencies and knowledge: The registered nurse needed experience and an understanding (sensitisation) of the specific needs of MSM, and the peer educators needed training in outreach work, as well as subject knowledge.

The uptake of PEP numbers remained low since the beginning of the project. Therefore, adjustments were made to:

a) The marketing strategy: Initially the focus of the marketing strategy was only on the gay media. OUT realised, however, that the gay media reaches only a very small portion of the gay target population, and not the MSM population. A decision was therefore made to include advertising in the mainstream press.

b) Another adjustment that was made, was to include mobile testing at sex clubs, and to focus the messaging on PEP Treatment. A specific PEP roll-up banner and PEP pamphlet were developed for this reason.

c) Then there was also a focussed effort to market PEP treatment on Facebook and Twitter. A specific advertisement was developed and money was allocated to have it displayed at certain intervals on social media.

d) Lastly the messaging on the monthly posters was changed to focus more on PEP Treatment, than only on HIV Testing.

The above changes were made, but it did not have any significant impact or influence (PEP uptake numbers did not show an increase), hence the Lessons Learned exercise to determine what the possible reasons could be.

An internal factor that shaped the activity, was the low uptake of services at the OUT Clinic, including low numbers in accessing PEP Treatment. An external factor was the indication that MSM still did not know about the availability of PEP Treatment.

The number of MSM that received PEP Treatment for the period (Jan14-Jun14), was 10 clients (qualitative).

The output target was 33 clients.

ANALYSIS AND LESSONS LEARNED

To which extend has the activity worked as intended?

About a third of the output target (30%) of the target population (MSM) accessed PEP Treatment. With all the added effort that OUT put in, more people are aware of the availability and benefits of PEP Treatment. As a result, OUT also has well developed BCC material to distribute in future.

To which extent did actual practice follow your theory of change, and were your operational assumptions valid?

Actual practice did not follow OUT's theory of change, and the operational assumptions seem to be invalid. The assumption was that through the implementation of the Programme, awareness of PEP, knowledge of PEP, and the uptake in numbers of clients accessing and using PEP, would increase.

Seeing that this was not the case (numbers remained very low), OUT wants to learn the reasons. The assumptions (theories) that OUT started with, with this Lessons Learned exercise, were that low uptake of PEP could be because people do not know about it and what it does. It would mean larger scale and continued marketing.

OUT is, however, interested in another possible underlying reason of why people do not use PEP. OUT believes it could be that gay men and MSM are not that concerned about prevention and HIV anymore. Human beings tend to act when something is wrong, and it is much more difficult to learn prevention behaviours. HIV could also be seen, as not that serious anymore, and the attitude could be that should one test positive, there is effective treatment anyway. If this is so, OUT would like to know from our target group, how we should do prevention (and the marketing thereof), especially around PEP and Pre-Exposure Prophylaxis (PREP).

Process

OUT decided to host two Focus Group Discussions (FGD) with different target groups to determine the key factors for the apparent failure of the project:

a) **Camp David Focus Group:** The first focus group (FG) consisted of patrons who frequently visit a sex club, Camp David. OUT used a place methodology to recruit the participants. Five participants were recruited, who represent the 30+ age group of MSM, with a middle- to higher income, who are mainly white and who are educated (tertiary qualification). They are not in monogamous relationships.

b) **Township Focus Group:** The second focus group consisted of 6 young black MSM (20+ years of age), coming from different township areas in and around Tshwane (Pretoria), who have a lower income, and who are either in the process of acquiring a tertiary qualification, or who do not have a tertiary qualification (one is a part-time student and another a full-time student). OUT used networking, through its peer educators, to recruit this group. They are either single or in monogamous relationships, and try to present their "ideal self".

For both focus groups OUT needed to establish trust and manage to elicit honest answers.

OUT asked 4 questions:

- How important is prevention?
- What is the role of different prevention technologies, especially condoms/lube and PEP/PREP.
- Reflecting on the OUT experience of doing extensive prevention work and the low uptake of PEP and PREP; why could this be and how does this relate to what people think under questions 1 and 2?
- People's view on treatment and if this could make prevention then less important.

Key factors that were identified, were ignorance (MSM are still unaware of PEP Treatment), and what OUT considers "the human condition" – a pretence or wishful thinking that "it will not happen to me" (I will not be infected with HIV). This is an almost careless attitude that most humans display, or an unwillingness to face reality and the seriousness thereof.

OUT learned the following from the two different focus groups:

Camp David Focus Group:

- This FG feels that we are "victims of our own success". The messaging about the success of HIV treatment, makes people complacent. A mass campaign was launched nationally on every level, and people took note. HIV is no longer a threat to people who are educated about it. People don't fear HIV that much anymore, since treatment is so effective and available.
- Because of the above, people are careless and has a "don't care" attitude. What they don't know, they don't worry about. If they don't get tested for HIV, they don't know their status, and then they don't have to take any responsibility for their actions.
- Unlike the huge emphasis on HIV messaging and the use of condoms and lube as prevention method (nationally), the same is not true of PEP. There hasn't been a similar mass campaign to make people aware of the possibility and availability of PEP treatment as prevention method. Therefore people still don't know about PEP.
- The respondents of the FG felt that OUT's marketing strategy didn't work effectively enough. It didn't reach the intended target population.
- A barrier to accessing PEP treatment, is the protocol that requires people to be tested for HIV first before PEP treatment can be initiated. The reason is, that should a person test positive for HIV, that person should be started on HIV treatment rather than using PEP for four weeks. However, since the respondents feel people don't want to know their status, they don't want to get tested for HIV first, and therefore they don't access PEP treatment either.
- Another barrier that was mentioned, is that people are afraid to let OUT staff know what their HIV status is for some unknown reason (the respondents couldn't point out any exact reason). After some discussion this appeared to be an irrational fear with no substantial back-up.

Township Focus Group:

- This FG feels that people still fear HIV, and the threat of HIV is still alive among people in township areas, as opposed to respondents of the other FG.
- People take prevention seriously, but because of the emphasis of the messaging (mentioned above), condoms and lube are viewed as the most important prevention method.

- Similar to the above FG, the respondents of this FG feel that very few people know about PEP treatment. Those who do know about PEP, are sceptical of using it. They think that once a person is infected, it cannot be undone. Some are scared of ARV medication and the side-effects thereof. It appears that stigma also plays a huge role. People are scared that should someone find out they are using PEP medication, it might be mistaken for ARV treatment and they would think the person is HIV positive. It appears that people know about PEP, but do not have the correct information.
- People are afraid to get tested. They are afraid to test positive, and having to take responsibility for their actions.
- People would rather take the risk of not knowing than having to deal with reality (part of what OUT calls the "human condition"). People would rather "turn a blind eye", and simply hope for the best (that it will not happen with me). They would rather just have fun, without dealing with a serious reality that hampers their freedom. Sometimes it is simply a case of being too lazy to take serious matters into consideration.
- People are also gullible. When they enter into a relationship (regardless of the duration), they refrain from practicing safe sex, and stop using any protection. They think that because their partner loves them, he would not infect them. Should condom failure occur, people are often unaware, or the inserting partner would keep quiet about it.
- Lack of access and lack of financial resources remain a problem for people in townships. Government clinics do not provide PEP treatment, and it is not free of charge. People cannot afford to go to a General Practitioner (GP) to get a script for PEP medication, and then pay for it. They often don't even have transport money, since they have to travel far.
- Fear of judgement from health care professionals, is a barrier, as well as practical implications, such as having to take time off from work to go and get tested. People find it difficult and uncomfortable to talk about their sexual behaviour, and compliance (using medication as prescribed, and getting tested after three months) is also a problem.
- OUT's first information pamphlet appeared to have been too comprehensive (too much information to read). Therefore people didn't really read it.

In summary:

- There are similarities between the two focus groups' responses, like the idea that people resist getting tested, and would rather take the risk of not knowing their HIV status, than dealing with reality (the "human condition"). Then there still appears to be a large number of people who do not know about PEP treatment, and among those who know about it, there appears to be many misconceptions about PEP. Uptake of PEP treatment remains low in both focus groups.
- There are also some interesting differences, such as idea that HIV still pose a huge threat to under-resourced and uneducated people, as opposed to resourced and educated people.

In the township group, the use of condoms and lube, remains an important prevention method, where the respondents of the sex club almost have a disregard for the use of condoms and lube. There is also a huge difference with regards to availability and access (although this makes no difference with regards to uptake).

OUT learned that the following could be done differently:

- pamphlet with less information could be developed. It could focus on only the most important, but necessary, information.
- Over-all messaging should place a bigger emphasis on PEP treatment, as prevention method. The use of condoms and lube received all the attention and effort in the past.
- A bigger marketing effort could be launched by OUT to create more awareness.
- A more direct approach could be followed at the sex club. Instead of relying on a banner and pamphlets only to invite people to come to the mobile testing unit, a person could hand out the pamphlets and tell people in short what it is about.
- OUT's Peer Outreach Workers could receive more training on PEP treatment to create greater awareness, either through face-to-face contact or mobile events.

- Another suggestion is to hand out incentives to motivate people to access PEP treatment (and get tested). A sponsor would be needed to procure the incentives.
- The protocol for administration of PEP treatment could receive attention. The question could be raised about the necessity of testing a person first for HIV, before initiating PEP treatment. The question is: Is there maybe another possible way?
- Lobbying is needed. Government needs to be accountable and launch the same marketing effort into making the greater public aware of PEP treatment.

WAY FORWARD

OUT wants to create greater awareness of PEP treatment and increase the uptake of PEP medication for the target population. A bigger outcome will be that Government provide PEP medication free of charge at Government Clinics, and increase access and availability to more people.

Some blocks may be that people will still resist accessing PEP treatment, because it is difficult for people to change their behaviour, especially sexual behaviour. It is also not easy to lobby for change in the way Government approaches prevention methods.

The first step for OUT will be to secure funding to continue providing PEP treatment to the target population, since the programme Proudly Combined came to an end during 2014.

It was very useful to learn why people didn't access PEP treatment. To an extent it confirmed OUT's theories about sexual behaviour and prevention methods. However, it also gave insight into the different ways of thinking that exist between people coming from different socio-economical, cultural and geographical backgrounds.

wIt clearly shows that different approaches would be needed for people from different backgrounds when addressing and marketing prevention methods and safer sex practices.

OUT will firstly make this Lessons Learned Document available to all the other organisations in the region that benefit from COC's partnerships.

The document could be shared with Government stakeholders as well, such as the National and Provincial Departments of Health, and act as a tool to spark debate on the issue.

ORGANISATIONAL BACKGROUND

OUT was founded in 1994 as a support group to support the needs of LGBTI people in Tshwane (Pretoria), South Africa. After a survey in gay spaces, a telephonic counselling line was introduced. After several needs analysis, it was found that gay people and MSM face discrimination when trying to access health services, and they have a need for competent health services. Therefore OUT offers direct health and mental health services, such as an on-site health clinic for HCT, STI and TB Screenings and general health needs, and also telephonic, electronic and face-to-face counselling services. OUT also offers sensitisation training for health care providers, and developed several training manuals. OUT is involved in advocacy work, advocating for legal rights and protection of LGBTI people, and has also been involved in several research projects.

Vision of the organisation:

OUT is dedicated to building healthy empowered lesbian, gay, bisexual and transgender communities in South Africa and internationally. OUT wants to reduce hetero-sexism and homophobia in society.

Mission of the organisation:

OUT works towards lesbian, gay, bisexual, transgender peoples' physical and mental health, and related rights.

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i) http://www.who.int/hiv/pub/guidelines/PEP/en/

ii) http://www.aidsmap.com/HIV-prevalence-among-South-African-MSM-twice-as-high-as-general-population/page/1323795/

iii) http://www.who.int/hiv/topics/prophylaxis/info/en/

iv) http://www.msmgf.org/files/msmgf/documents/TechBulletins/EN/Sec4MSMGF_TechBulletins2012.pdf

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