Minding the Gaps:

MSM &HIV

Kevin Rebe

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PEPFAR

USAID FROM THE AMERICAN PEOPLE

Western Cape Government Health

BETTER TOGETHER.

Why the term 'MSM'?

- It means ***Men who have Sex with Men***

- MSM include 'gay' men, 'homosexual' men, 'bisexual' men, 'after-nine' men, 'moffies', 'queers', ***straight men*** etc.

- MSM is **behaviour**

- MSM is ***not an identity***

The term is important because:

- ***Behaviour places men at risk not***

MSM & HIV in South Africa: What we know and don't know…

- How many MSM in South Africa
  - 750 000 – 1,5 million MSM (Jobson et al, 2014)
- HIV Prevalence?
- HIV/AIDS/STI/TB burden of disease?
- High transmission areas?
- Sex with women about 50% (Lane, T et al, 2012)
- Package of care for MSM?

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Definition: Key Populations

- **Key populations** are:

Men who have sex with men
Prison populations
People who inject drugs
Sex workers

Key populations are recognised ***internationally***.

- **Vulnerable populations** are:

Adolescents and young women
Scholars
Immigrants
Others

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Vulnerable Populations in South Africa

Specific groups have HIV prevalence above national average (12.2%). They include:

- Black women aged 20–34 years (HIV prevalence 31.6%),
- People co-habiting (30.9%),
- Black men aged 25–49 years (25.7%),
- Disabled persons 15 years and older (16.7%),
- High-risk alcohol drinkers 15 years and older (14.3%),
- Recreational drug users (12.7%).

Shisana, O et al. (2014) *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.*

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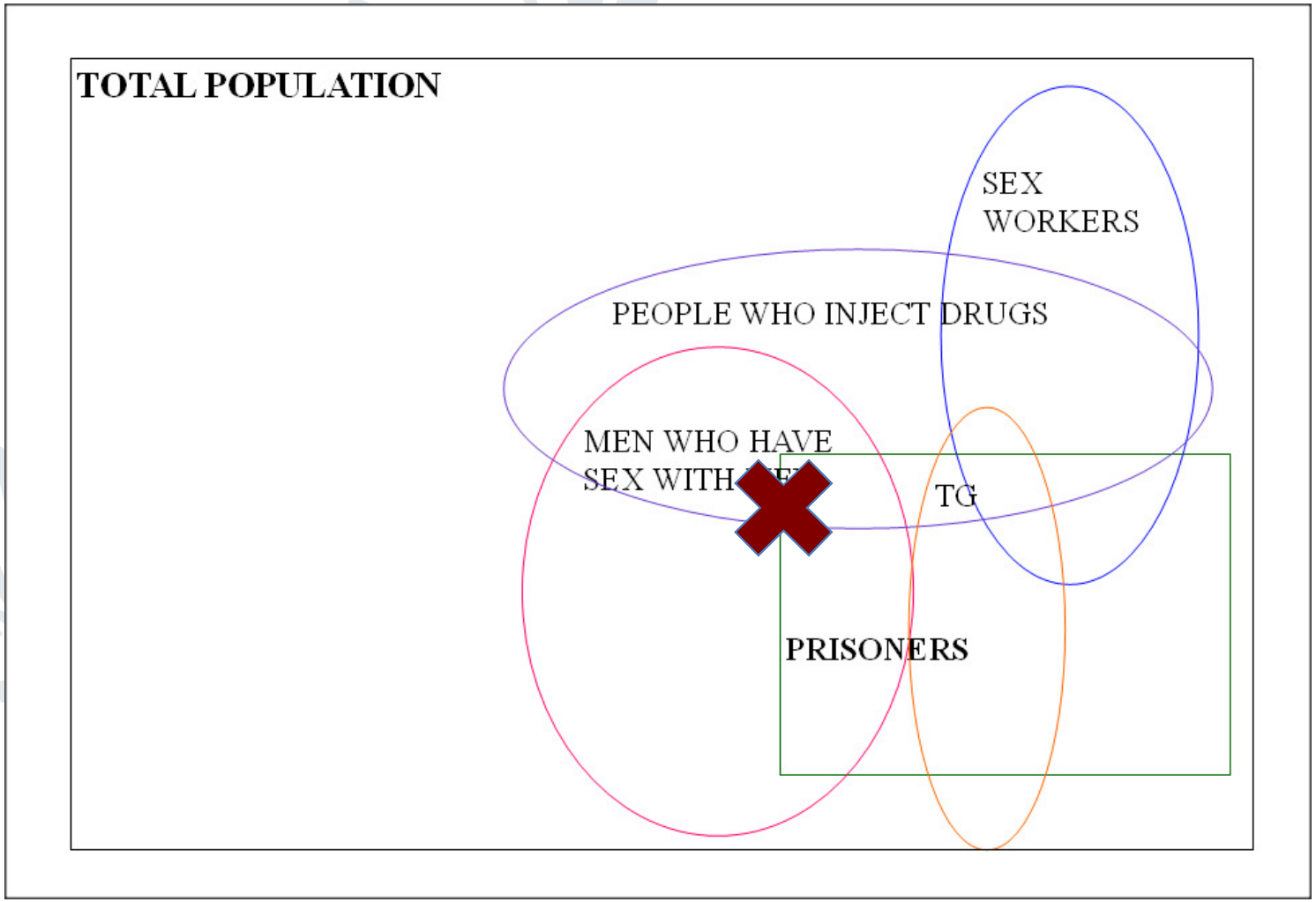
Key Populations



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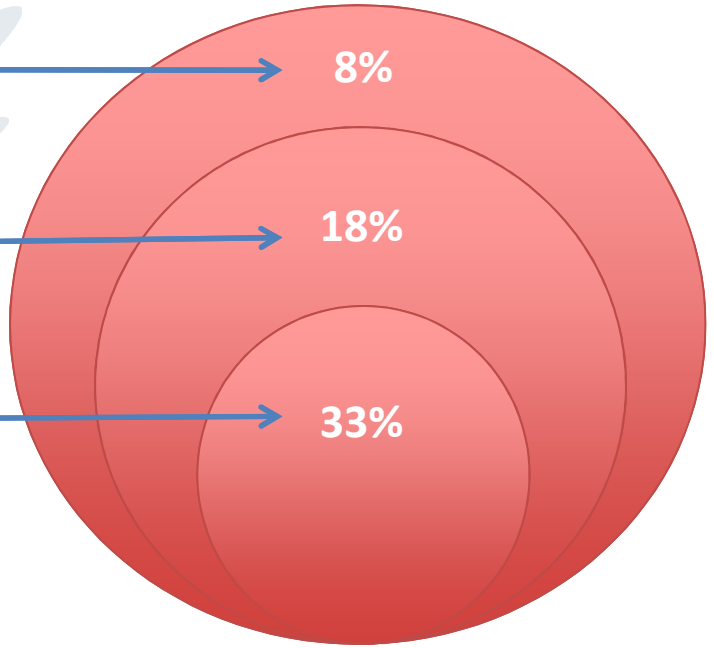
Intersection of Key Populations:

Crane Study 2013: Kampala, Uganda

HIV Prevalence Kampala

Client / partner prevalence

Female Sex Worker prevalence



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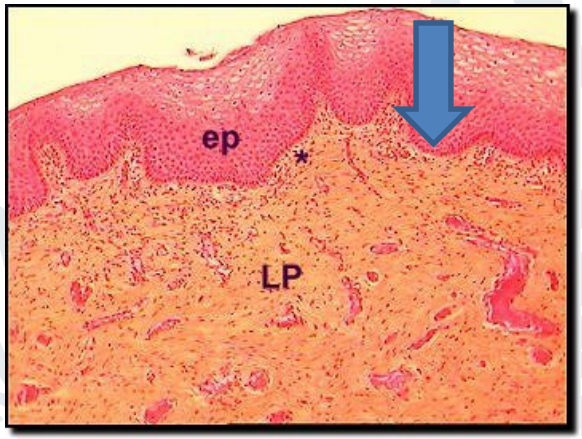
MSM Behaviours and HIV

Unprotected Anal sex →

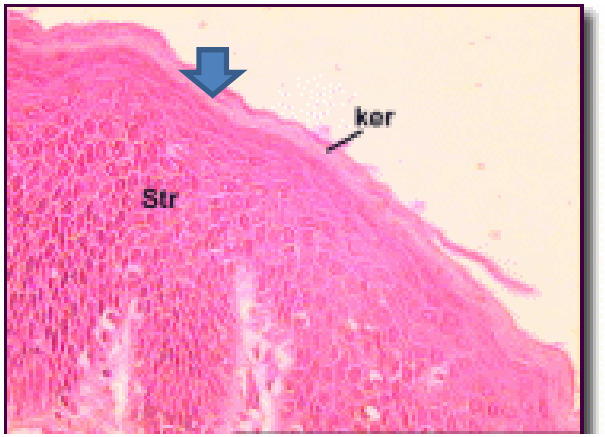
Risk of HIV transmission 1.4% (18 X vaginal sex risk) Baggaley, R et al.

Vagina



Adapted for sex
Thick mucosal surface
Self lubricating before sex

Anus



Not adapted for sex
Thin mucosal surface
Not self lubricating
→ Mucosal tears → HIV entry-point

Most anal sex occurs between men & women!

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HIV Prevalence in South African MSM

Study site	Year	Lead Author	Study Type	Sampling Method	No of particpants	HIV
GT, KZN, WC	2003-2005	Sandfort	Behavioral, cross sectional	Snowball	1045	Not reported
GT	2004-2005					Not reported
Pretoria	2008					Not reported
Soweto	2008		cross sectional			**13.2 (12.4-13.9)**
Jhb, Durban (JEMS)	2008	Rispel	Bio-behavioral,	RDS	204	**49.5 (17.0-56.5)**
Cape Town	2008					**10.4 (CI not reported)**
Cape Town (peri-urban)	2009					**25.5 (CI not reported)**
Pretoria	2009	Tun	Behavioral, cross sectional	RDS	307	Not reported

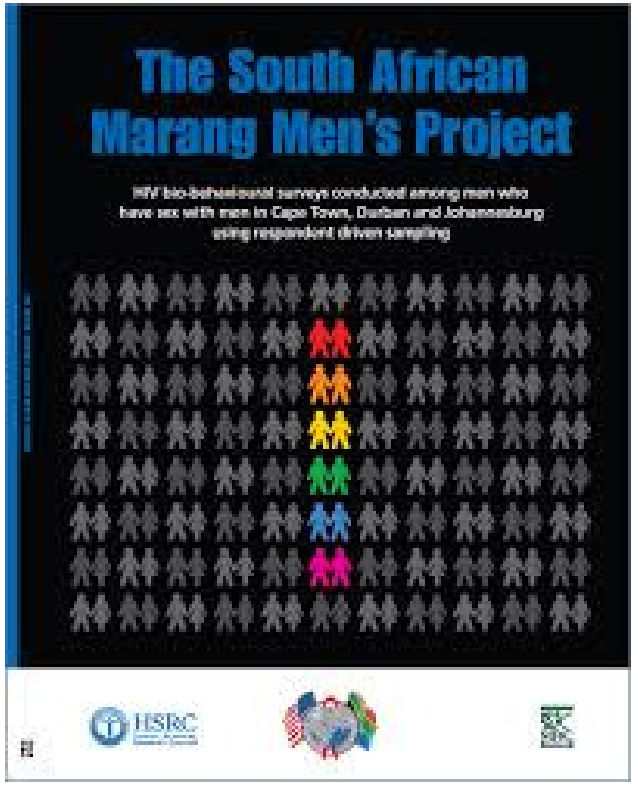
Increased HIV risk compared to general population (OR 3.8 in South Africa)
[Baral et al 2007]

MODELING DATA:

Providing targeted programs for key populations benefits a country's overall HIV response and decreases overall HIV rates
[Beyrer et al MSMGF Conference Vienna 2010]

HIV Prevalence in South African MSM

- Marang Men's Study (2012-13)
  - Durban 48.2%
  - Cape Town 22.3%
  - Johannesburg 26.8%
- Mpumalanga Men's Study (2014)
  - Gert Sibande 28.3%
  - Ehlanzeni 13.7%



National HIV prevalence SA men (15-49yrs) 14.5%

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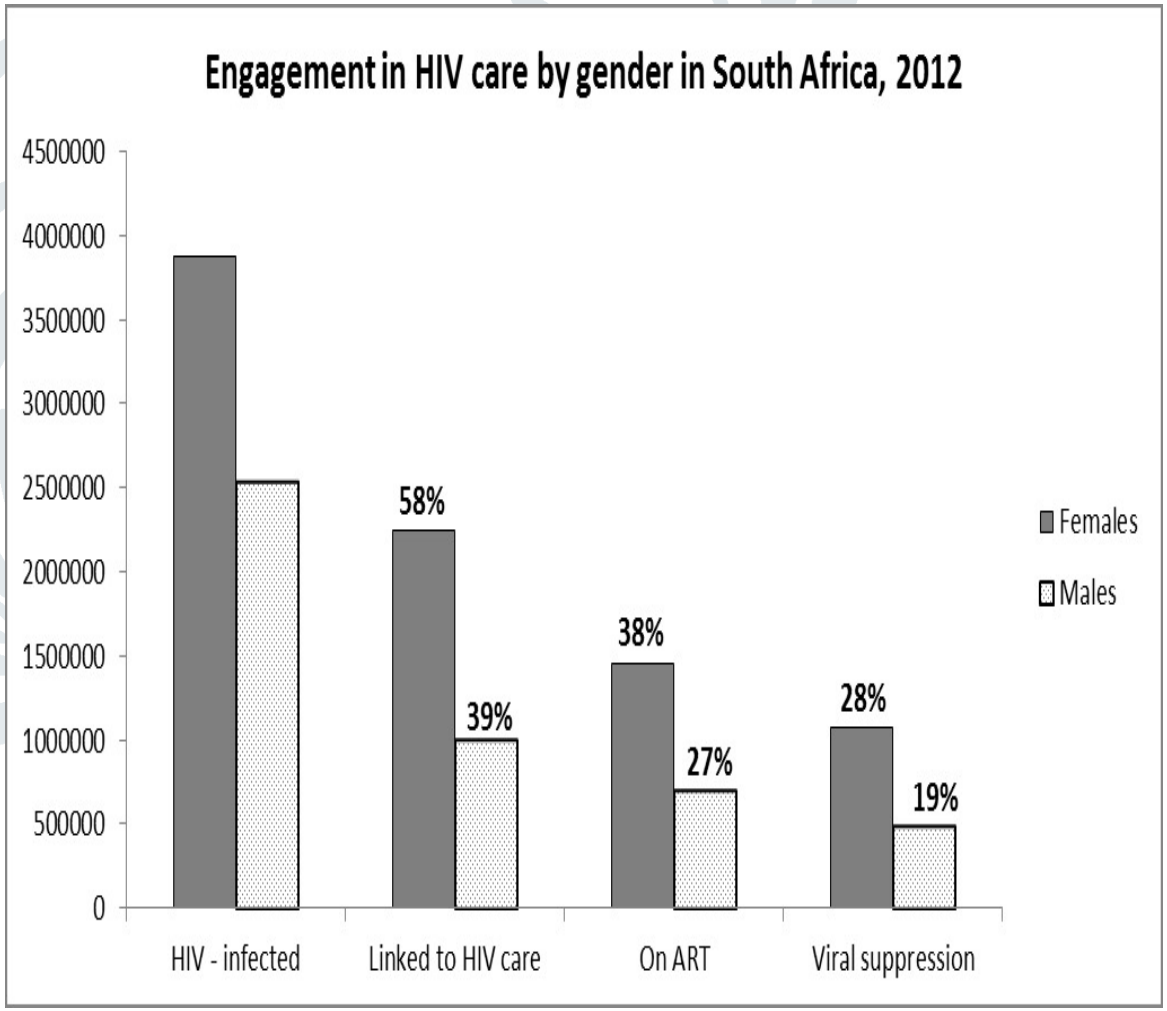
Men and the Treatment Cascade (South Africa)



- Gender gap in engagement
- Men in SA engage much less
- Important to note that men in KP groups are even more vulnerable than men as a group. (Lancet 2012)
- Important implications for TasP

Takuva S et al; Disparities in Engagement Within HIV Care in South Africa, CROI 2015 February 23-26, 2015. Seattle, Washington Abstract #154

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MSM (often) have sex with Women

- "85.0% of men with a history of consensual sex with men reported having a current female partner"
  - 98.9% of MSM had ever had sex with a woman.

- 27.7% reported having a current male partner
  - Of these 80.6% also reported having a female partner

Dunkle KL, et al. Prevalence of Consensual Male-Male Sex and Sexual Violence and Associatons with HIV in South Africa: A Population-Based Cross Sectional Study. 2013. PLoS Med 10(6): e1001472.

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Sexual Activity of MSM

- Ranges from no physical contact to penetration
- No physical contact includes:
  - visual stimulation (for example webcam sex)
  - telephone sex
  - masturbation
- Physical contact may include:
  - kissing
  - oral-penile, penile-anal, digital-anal, oral-anal

- Being a MSM is not high risk, but specific *behaviours* may be high risk

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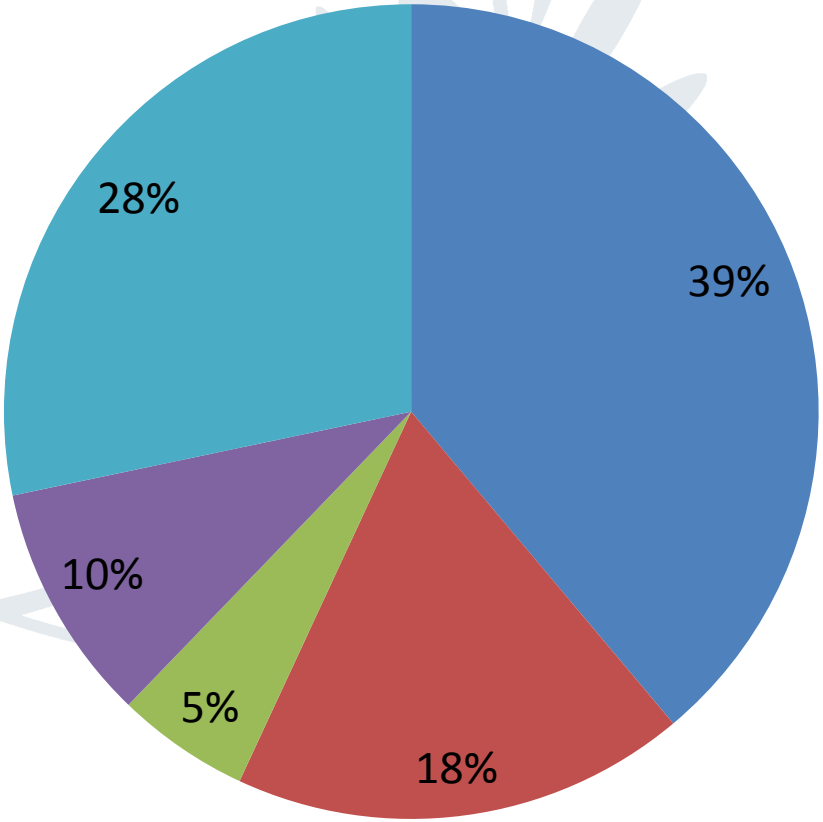
MSM and High Risk Sexual Behaviours
Condom use during receptive anal sex
(last 6 months)



H4M Online survey
1400 participants

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Why MSM?

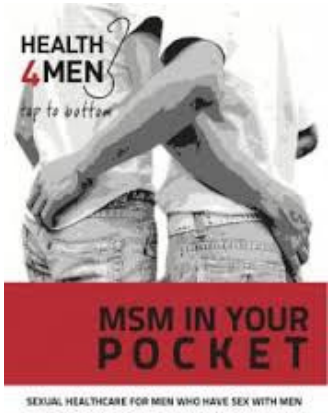
MSM are becoming a priority for targeted health interventions & research

- US National AIDS Prevention Plan
- PEPFAR Guidance (and Global Fund)
- South African National and Provincial Strategic Plans

Interface with heterosexual epdimic (50% are MSM/W)

High population prevalence = failure of existing HIV prevention interventions

Challenges to Address



- Homosexuality seen as unAfrican, unChristian…
- Majority of MSM also have sex with women (MSMW) and identify as heterosexual
- Confluence of key populations – sex work, transactional sex, refugees, transgender people, mental health challenges
- Substance abuse – harm reduction programme instituted in Cape Town with needle exchange
- Gaining trust, meaningful engagement
- Funding and sustainability

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Clinical Challenges to Address

- Barriers to MSM seeking health care include endemic homoprejudice and related stigma, analphobia and discrimination – also within the public health system
- MSM not a homogenous group – share a range of common *behaviours* (which are often clandestine and denied) as opposed to sharing an *identity*
- Asymptomatic STIs and MDR gonorrhoea
- Substance abuse
- HCV and HIV co-infection
- Mental health disease burden

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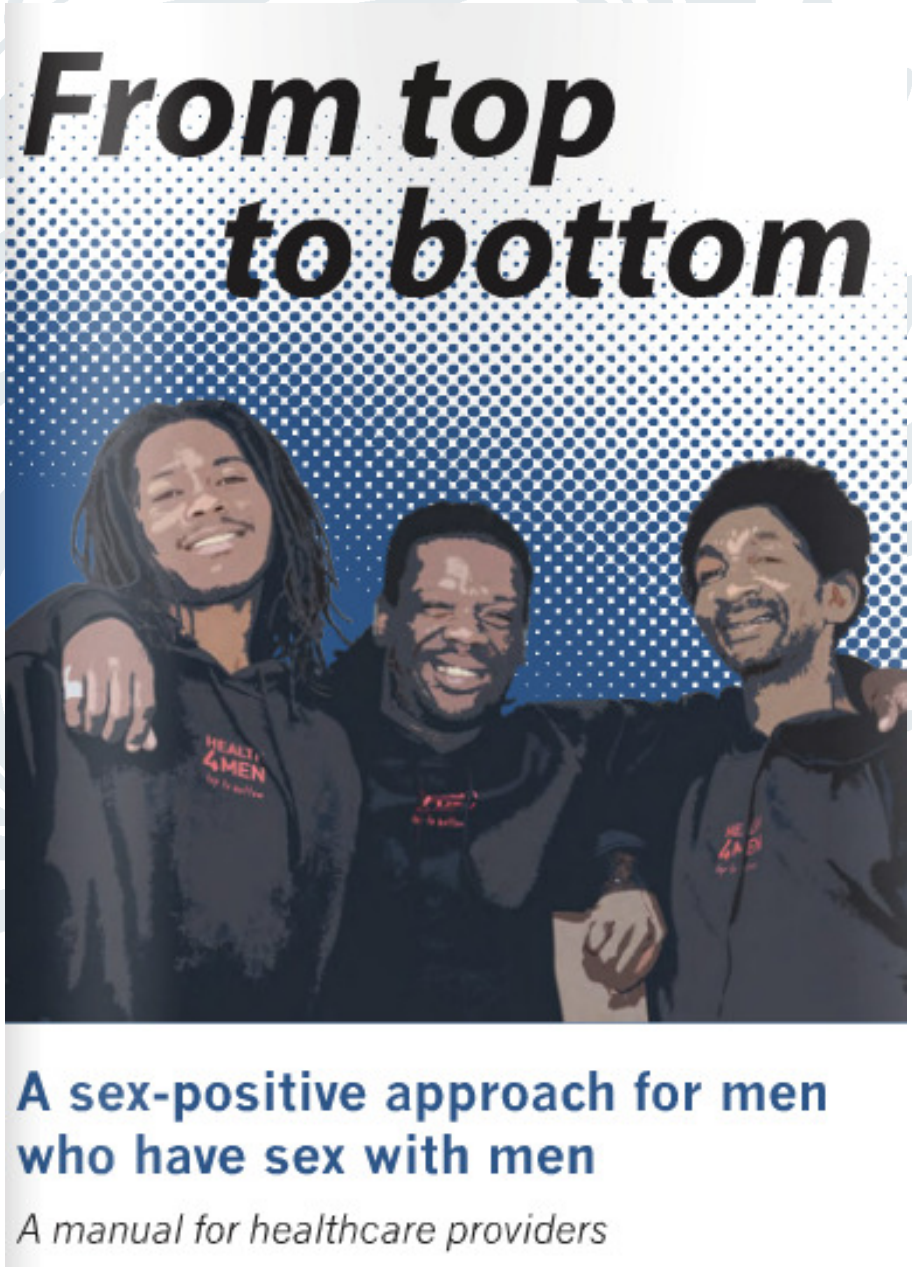

HEALTH 4 MEN
top to bottom

The Health Care Worker and MSM: A Sex Positive Approach

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Legal Issues & Obligations

- South African Constitution 1994
  - No discrimination on Grounds of Sexual Orientation (Bill of Rights)

- Declaration of Geneva:

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

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The Health Worker is from/of the Community

- May have the same attitudes, prejudices, discomforts, thinking, religion or faith.
- May or may not be aware of them.
- Those things affect their work.

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Health Care Workers (HCW)

Or why MSM don't trust HCWs:

- HCW stigma can be a major barrier to access
- Weak health care systems
- Lack of sensitivity and competence
- Health providers on MSM:
  - "They don't come to us…", "They don't tell us…"
- MSM Health consumers on HCWs:
  - "They laugh at us…" , "They tell everyone…"

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Prejudice and Healthcare

- Attitudes, stereotypes, myths and prejudice can create barriers to access and use of healthcare.
- Negative attitudes affect the way health workers engage and communicate with patients.
- Barriers to using health services weaken the fight against the HIV epidemic and result in poorer health outcomes for the community.

Do you have sex with women, men or both?

Can I examine your anus to excude STI's?

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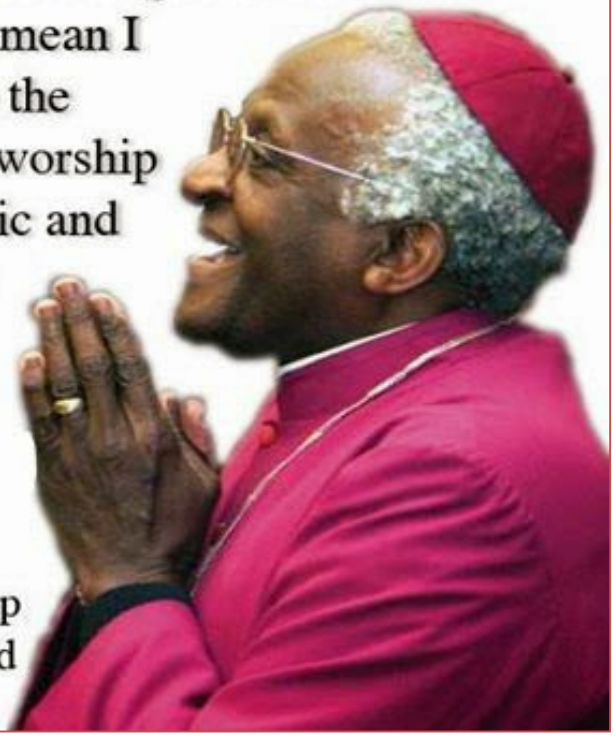
"Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us."

Ban Ki-moon, UN Secretary-General

"I would refuse to go to a homophobic heaven. No, I would say, sorry. I mean I would much rather go to the other place. I would not worship a God who is homophobic and that is how deeply I feel about this. I am as passionate about this campaign as I ever was about apartheid."

South African retired bishop Desmond Tutu, 81 years old



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Creating the Right Environment

- Make ***all patients*** feel equally welcome
  (Not a "gay-identified" space)
- Privacy for consultation
  (Concern about disclosures of sexuality and status)
- Use patient's name, gender pronouns (TG)
  (Use their terms, not ours... Ask if/when not sure!)
- Posters addressing diverse sexual health needs of men
  (No breastfeeding posters)
- Monitor your own response AND *the colleagues you supervise*

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Culturally Appropriate Health Messages

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Core Key Population Services Identified by WHO

- HIV screening and treatment (CD4 <500 cells/mm^3)
- Management of HIV related illness
- Appropriate counselling and support
- Prevention – PEP and consider PrEP
- Prophylaxis
  - IPT / Fungal / Co-trimoxazole
- STI prevention, screening and treatment
- Malaria prevention (specific provinces)
- Vaccination e.g. hepatitis B, pneumococcal, flu
- Integrated TB services – South Africa

World Health Organization

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Testing Recommendations

- Need to shift HIV testing promotion from one-off model, to *Repeated, Routine, Health Maintenance Behavior*

- Public health research from *'ever'* testing, to assessment of *'repeat'* testing.

HCT Recommendations for MSM:

Test regularly according to sexual risk

Sensitive and competent ("Not who is the man & who is the women in this relationship…")

Effective risk reduction counselling

Linkage to care (both positives and negatives)

Promote couples counselling

Use technology (e.g. Find a clinic or home-based testing)

STI's Are A "Hook"

STIs may ⇧HIV disease burden:

- Disrupt mucosal barriers
- Cause sub-endothelial inflammation
- Increase viral load
- Marker for risky sexual behaviours

Provide additional services

- Risk assessment for HIV
- HIV testing and linkage to care
- Screen for alcohol and substance use
- Screen for mental health problems

Build clinical relationships

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A Little Anatomy

Pharyngeal
- Receptive oral sex
- Rimming

Urethral
- Penetrative oral sex
- Penetrative anal sex

Anal
- Receptive anal sex
- ?Rimming
- ?Sex toys

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Drivers of High STI Rates

- **High rates of unprotected sex**
  - Prevention message fatigue
  - Lack of condoms or lube
- **Presumed level of safety**
  - HIV and STIs are manageable
  - Advertising by pharmaceutical companies
- **Modern youth**
  - Earlier onset of sexual debut
  - More sexual partners
  - More exposure to sex (e.g. internet)
  - Recreational substances

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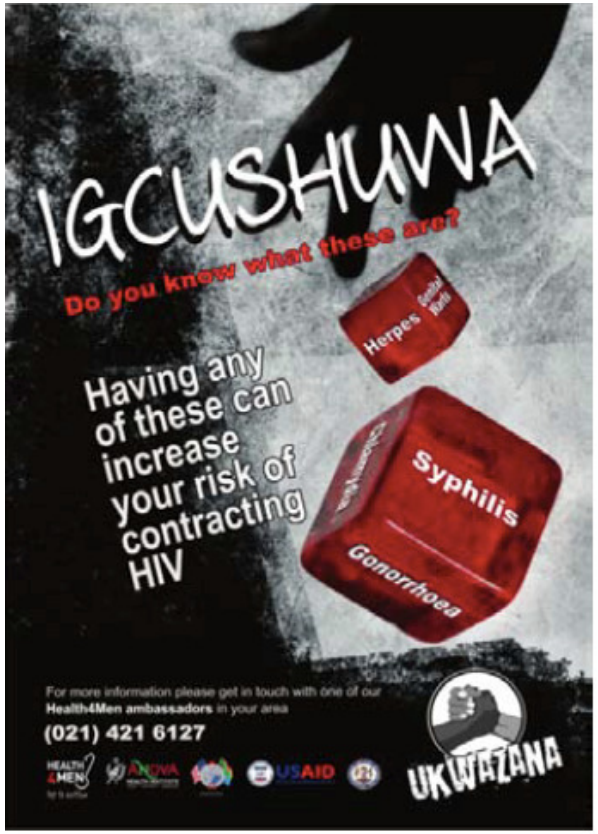
Asymptomatic STIs

- Syphilis
- Hepatitis and other sexual viruses
- HIV

- The majority of gonorrhoea and chlamydia are symptomatic in MSM
- 1 in 4 screened positive for ASTI (In Press)



ASTI Treatment Guidelines

CDC (and various USA & EU guidelines)

Yearly syphilis

PCR screening of pharynx, anus and urethra based on sexual history

WHO: Presumptive STI treatment for at risk MSM

Reported UAI in the last year PLUS

Partner with an STI OR

Multiple partners

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The Empiric Syndromic Approach To STI Treatment

New Syndromic Guidelines:

Replace cefixime with ceftriaxone

Replace doxycycline with azithromycin

This is the current approach advocated by the SA Department of Health.

Not addressing STIs among MSM:

No syndrome if asymptomatic
No determination of GC resistance
Little consideration of non-urethral infection sites
No monitoring of LGV and other STIs

Undertreated GC promotes HIV transmission

- Key Populations prevalence already high → high community viral load

- Highly effective HIV transmission in UAI (20 X vaginal sex risk) Baggaley, R. Int J Epi. 2010.

- Untreated urethritis increases seminal HIV viral load by a factor of approximately. Cohen, M. Lancet. 1997.

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Contact Tracing and Key Populations

- Best practice STI management includes contact tracing but difficult in Key Populations because:
  - Social and sexual networks often hidden
  - May have been casual contact
  - Sex in public spaces
  - Anonymous

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Syphilis

- Key Populations have chancres in atypical sites e.g. Anal / rectal / oral / vaginal
- Increasing rates in developed and developing world
- Increases transmissibility of HIV
- Some evidence of increased viral load in HIV positives
- Interpreting serology

Diagnosis can be difficult

RPR can miss early disease

THPA may remain positive post treatment

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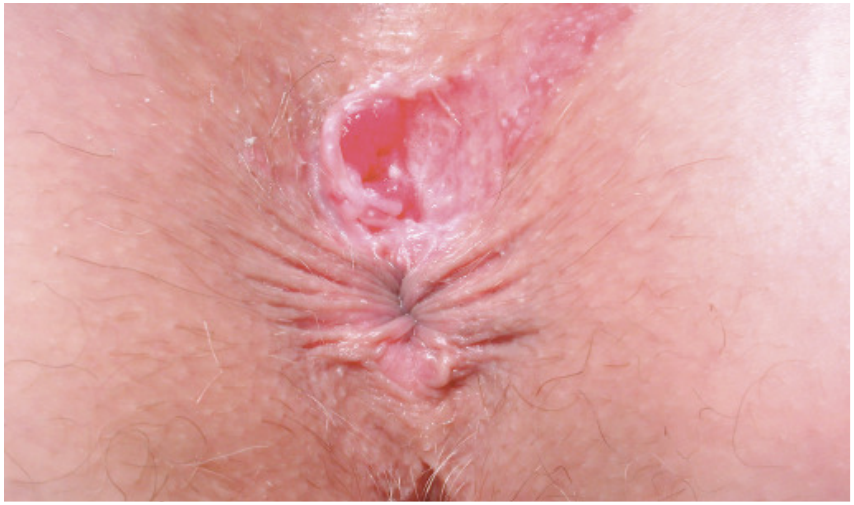
HPV, Anal Health, AIN and Cancer

- HPV commonest STI seen at the Ivan Toms Clinic in Cape Town
- Increased risk of HPV infection, infection with multiple serotypes and oncogenic serotypes
- HIV positive MSM at increased risk of
  - HPV persistence
  - Anal cancer
- Anal examination is usually not done for MSM attending heteronormative HIV services
- No AIN screening exists
- Boys are excluded from HPV vaccination programs



Recommendation of qHPV Vaccine for Men

- All men age <21 years
- MSM or those who have a compromised immune system (including HIV) <26 years
- All SW should also receive HPV vaccine.

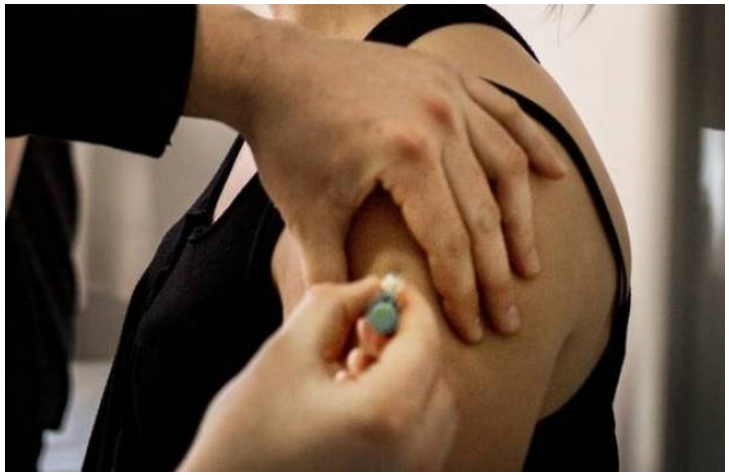
What about sexually active MSM?

What about MSM with prior HPV?

Too little too late?

Why Cervarix?

Why systematically exclude the highest risk group?



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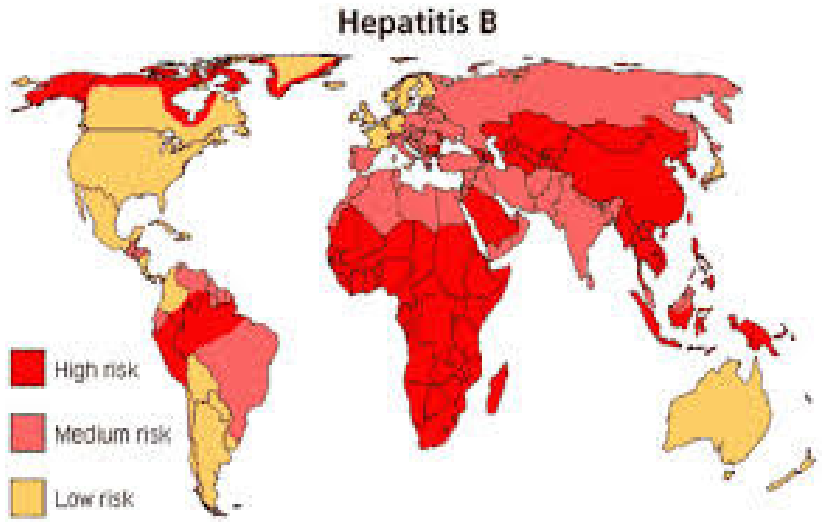
Hepatitis B (HBV)

- SA carries 18% of global burden of HBV
- HIV and HBV co-infection common in Africa
- Worse outcomes if HIV and HBV co-infected
- More expensive and complicated ART regimens

MSM <u>not</u> prioritized by the NICD for catch up vaccination

1/41 Recently screened MSM had demonstrable hep B immunity



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Hepatitis C (HCV)

- IV drug use (other drug use?).
- Sexual spread during unprotected anal sex.
- Much worse outcomes if HIV and HCV co-infected.
- No vaccine and often no accessible cure.
- Up to 85% of infections become chronic.
- Re-infection can occur.
- New Hep C PI's unobtainable.

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Hepatitis C in South A rican Key Po ulatio

- 313 H e p V
  - 170 (5
- 10 (3
  - 9 (5.3%) i
  - 1 (0.7%) SM .02

11/41 (25%) drug-using MSM in Cape Town screened positive for Hep C IgG

Gclokela N, Sonderup, M, Rebe K et al. SAGES. Balt 2013.

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Shigella flexneri: A Cause of Significant Morbidity and Associated With Sexually Transmitted Infections in Men Who Have Sex With Men

Cresswell, FV et al, Shigella flexneri: A Cause of Significant Morbidity and Associated With Sexually Transmitted Infections in Men Who Have Sex With Men Letter to the Editor, STD, 2015; (6) 42(6) - p 344

Enterobacteriacea. Usually a self limited, mild diarrheal illness. Feacal oral transmission. Been noted Sexually transmitted before.

- Can cause severe illness
  - Hospitalisation
  - Acute Kidney injury (ARF)
- Associations
  - HIV infection
  - Recreational drugs

- All MSM
- HIV pos (54%) and neg
- ARV no difference.
- Viral suppression, immune reconstitution not protective

- Not a benign infection
- Marker of unprotected sex and possible resence of other STIs
- Further management, partner notification, patient education

HIV Treatment For MSM

- **MSM-appropriate HIV screening**
- **CD4 monitoring pre-ART**
- **(VL monitoring on ART?)**
-
-
-

Appropriate HIV screening / HCT

- Sensitivity from counselor
- Able to take a sexual history
- Understands normal range of sexual behaviours including anal sex
- Able to identify risks of HIV transmission
- Able to council about risk reduction

en

  - Side effects such as erectile dysfunction and diarrhoea
  - Earlier treatment for prevention given high transmisibility of HIV during unprotected anal sex

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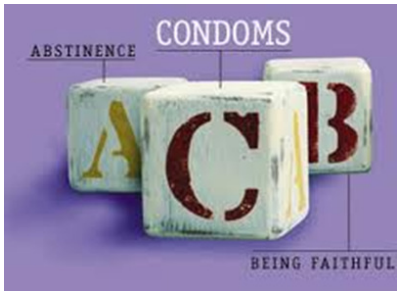
The HIV Prevention Menu for Men

- ABC…
- Biomedical
  - Devices such as condoms / lube
  - Medicines including, PEP, PrEP and TasP
  - Microbicides and vaccines
  - Medical male circumcision
  - Screen and treat STIs
- Structural
  - Decreasing institutionalised prejudice
  - Clinic opening times
- Psychosocial / behavioural
  - Decrease partner numbers, increasing HCT
  - Sero-adaptive behaviours



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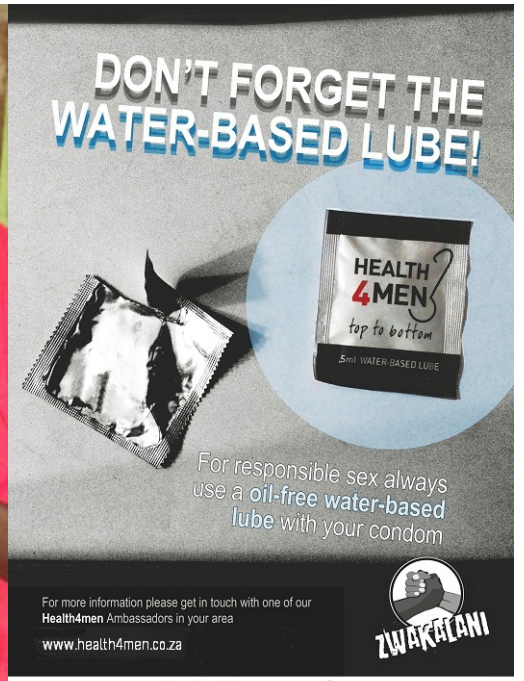
Condoms …and Lube!

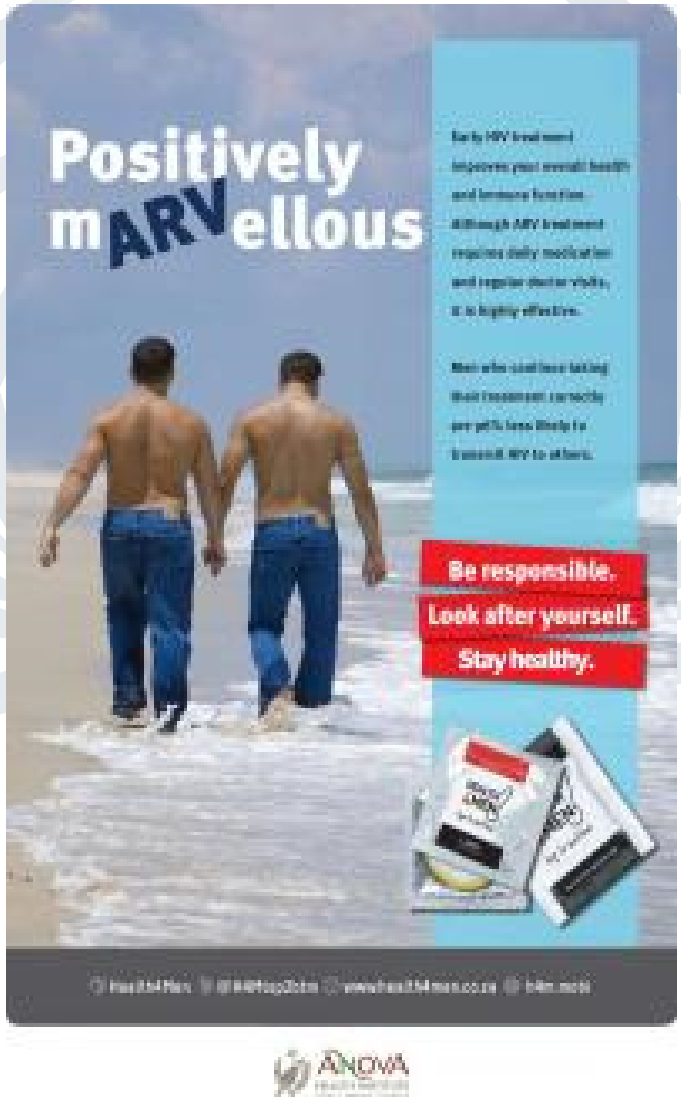
- **Appropriate lubricant**:
  - Water-based?
  - Rectal toxicity
  - Osmolality



- Utilise peer educators / Ambassadors, Men Of Action project, shebeen, inovative IEC messaging, leveraging mHealth and e-Learning etc…

Using lubricants for >80% of anal sex acts is significantly associated with decreased [condom] failure rates in the insertive model.

ARV-based Preventions



- Post exposure prophylaxis (PEP)
- Pre exposure prophylaxis (PrEP)

  (Note: this is not available in government facilities)
- Early treatment ARVs (TasP)

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Post Exposure Prophylaxis (PEP)

Already used for:

- PMTCT
- Post needle stick
- Post rape
- After possible sexual exposure

Barriers to access and limited use!

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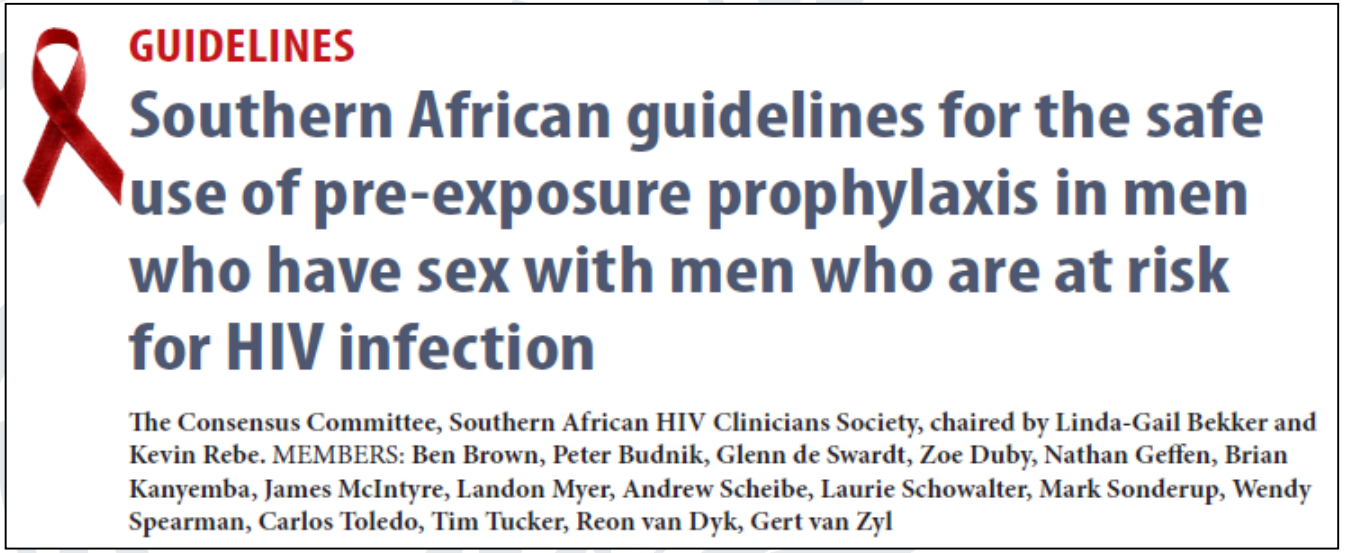
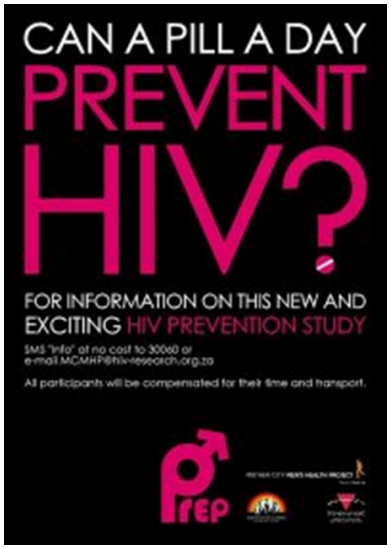
PrEP for MSM



GUIDELINES

Southern African guidelines for the safe use of pre-exposure prophylaxis in men who have sex with men who are at risk for HIV infection

The Consensus Committee, Southern African HIV Clinicians Society, chaired by Linda-Gail Bekker and Kevin Rebe. MEMBERS: Ben Brown, Peter Budnik, Glenn de Swardt, Zoe Duby, Nathan Geffen, Brian Kanyemba, James McIntyre, Landon Myer, Andrew Scheibe, Laurie Schowalter, Mark Sonderup, Wendy Spearman, Carlos Toledo, Tim Tucker, Reon van Dyk, Gert van Zyl



- Concept proven! It works for (expecially) MSM
- Adjunct to TasP
- Ideal dosing interval and long term side effects unknown
- Truvada is probably not the ideal PrEP drug
- Patient selection and adherence are key

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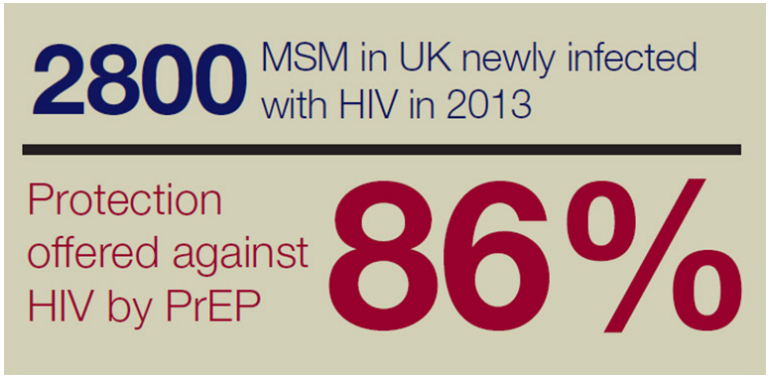
Four Early Trials Demonstrating PrEP Efficacy in Diverse Geographic and Risk Populations

Study, population	PrEP agent	# of HIV infections		PrEP efficacy (95% CI) publication
		PrEP	placebo	
Partners PrEP Study Heterosexual couples Kenya, Uganda (n=4758)	TDF/FTC	13	52	**75%** **(55-87%)**
	TDF	17		**67%** **(44-81%)** Baeten et al. N Engl J Med 2012
TDF2 Study Heterosexuals Botswana (n=1219)	TDF/FTC	10	26	**62%** **(16-83%)** Thigpen et al. N Engl J Med 2012
Bangkok Tenofovir Study (BTS) IDUs Thailand (n=2413)	TDF	17	33	**49%** **(10-72%)** Choopanya et al. Lancet 2013
iPrEx MSM Brazil, Ecuador, Peru, South Africa, Thailand, US (n=2499)	TDF/FTC	36	64	**44%** **(15-63%)** Grant et al. N Engl J Med 2010

PROUD Study UK



- 545 MSM recruited to take Truvada PrEP
- Immediate or delayed initiation with 24 months follow up
- Study stopped early by DSMB as efficacy dictates that continuing would be unethical
- Efficacy =86% (90% CI: 58 – 96%) P-value =0.0002
- Number Needed to Treat =13 (90% CI: 9 – 25)
- HIV incidence amongst gay men in England is much higher than what was thought.
- There was no difference in the rate of STIs other than HIV
- The use of Truvada for PrEP was safe and concerns about resistance are minimal.
- PrEP can be delivered as part as routine HIV reduction package

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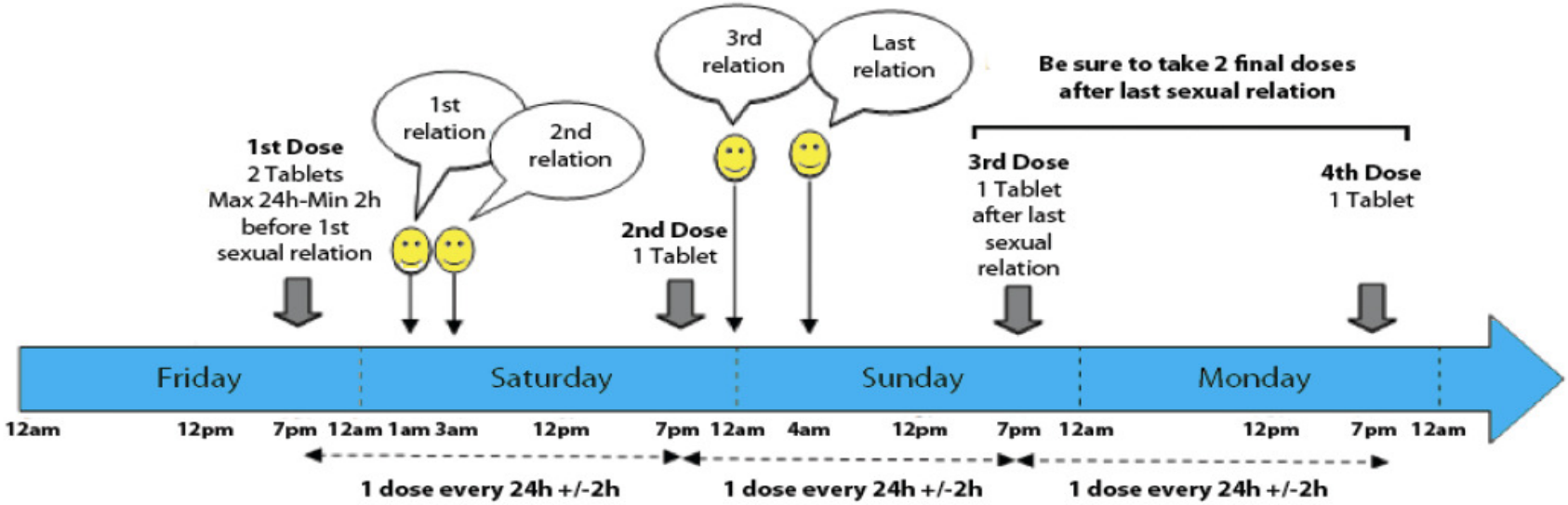
IPERGAY France



- RCT of Truvada versus placebo in 400 recruited high risk MSM
- Sex-based dosing (4 or more doses)
- Relative RR of HIV indidence was 86% (95% CI 40% to 99%, P = 0.002)
- Number needed to treat for 1 year to prevent 1 infection was 18.
- Also stopped early by DSMB because of high efficacy

86%

- Very sexually active
- Did they not by default get almost daily dosing?

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Concerns About PrEP Delivery

- Who pays? (DOH keen but not committed)
- Bundling with other services (e.g., FP for women or HAST clinics, doctor or nurse driven)
- Community delivery to create demand and reduce burden on facilities?
- Minimise frequent visits and costs
- Risk screening for targeting (e.g. condomless anal receptive sex for MSM, risk score for serodiscordant couples)
- Adherence monitoring?

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●●○○○ MTN-SA 8:49 AM 98%

PrEP Facts: Rethinking HIV Prevention a...

●●○○○ Verizon 01:52 95%

Chats Edit

Today

01:50 I get that, for sure. I'm on PrEP though, so I don't have to worry about HIV

01:52 That's also a new drug, something else will go wrong with it, just like all other pharmaceuticals. Side effects, and just like flu shots. You're injecting yourself with HIV a little every day.

01:52 Hahaha that's totally not true at all

+ Send

Q W E R T Y U I O P

A S D F G H J K L

15 Likes 18 Comments

●●●○○ MTN-SA 8:48 AM 98%

PrEP Facts: Rethinking HIV Prevention a...

4:51 AM

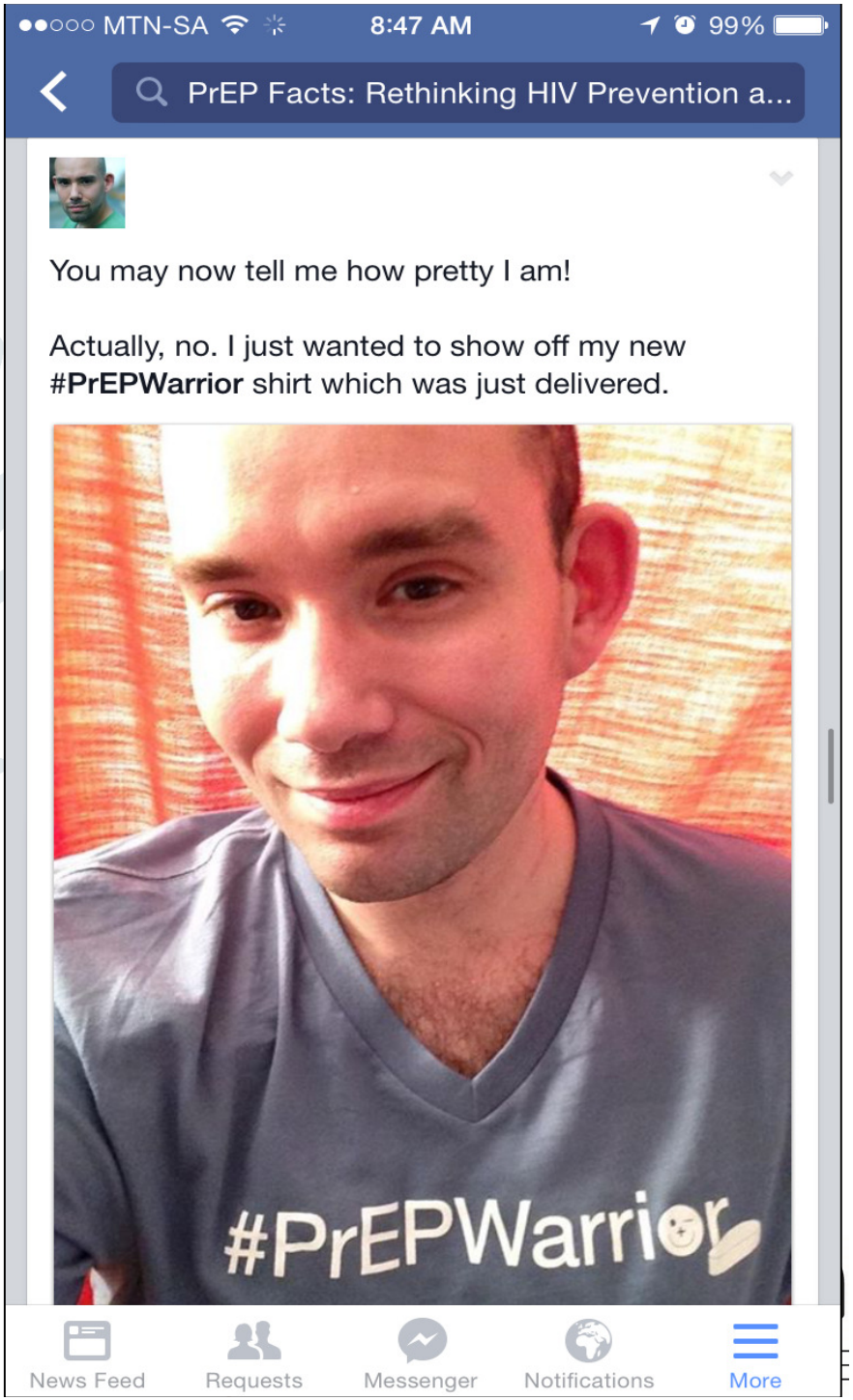
I couldn't resist ...

39 Likes 6 Comments

Like Comment

News Feed Requests Messenger Notifications More


●●○○○ MTN-SA
8:48 AM
98%
PrEP Facts: Rethinking HIV Prevention a...
After 8 months, I am victorious! Thank you to all who have supported and advised me here
Truvada
News Feed
Requests
Messenger
Notifications
More


●●○○○ MTN-SA
8:47 AM
99%
PrEP Facts: Rethinking HIV Prevention a...
You may now tell me how pretty I am!
Actually, no. I just wanted to show off my new #PrEPWarrior shirt which was just delivered.
#PrEPWarrior
News Feed
Requests
Messenger
Notifications
More

A fly in the ointment….

- HIV testing is a major cost-driver
- HIV self-testing will simplify, make more efficient AND make programmes cheaper
- PEP to PrEP (or not…)

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Treatment as Prevention (TasP)

HIV transmission needs:

- Many copies of HIV virus
- An entry point into someone's body

Thus

- Lowering viral load lowers transmission

Questions

- Should we treat Key Populations early, because of high risk of transmission?
- Should we treat the highest risk Key Populations ? (Discordant couples, SW, IDU, TG)
- Not a proven strategy yet but might be effective and evidence is increasing. *(Das et al and Cowan et al).*

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The PARTNER's Study: CROI 2014

PARTNER STUDY

- 1110 sero-discordant couples, nearly 40% gay male couples
- Sex without condoms at least some of the time
- No PREP/PEP for HIV negative partner
- HIV positive partner on ART with VL < 200 copies/ml

PROVISIONAL RESULTS:

- No-one with an undetectable viral load (cut off was 200 copies/ml), gay or heterosexual, transmits HIV in first two years
- Viral load suppression reduces risk of HIV transmission by `at least` 96% during anal sex

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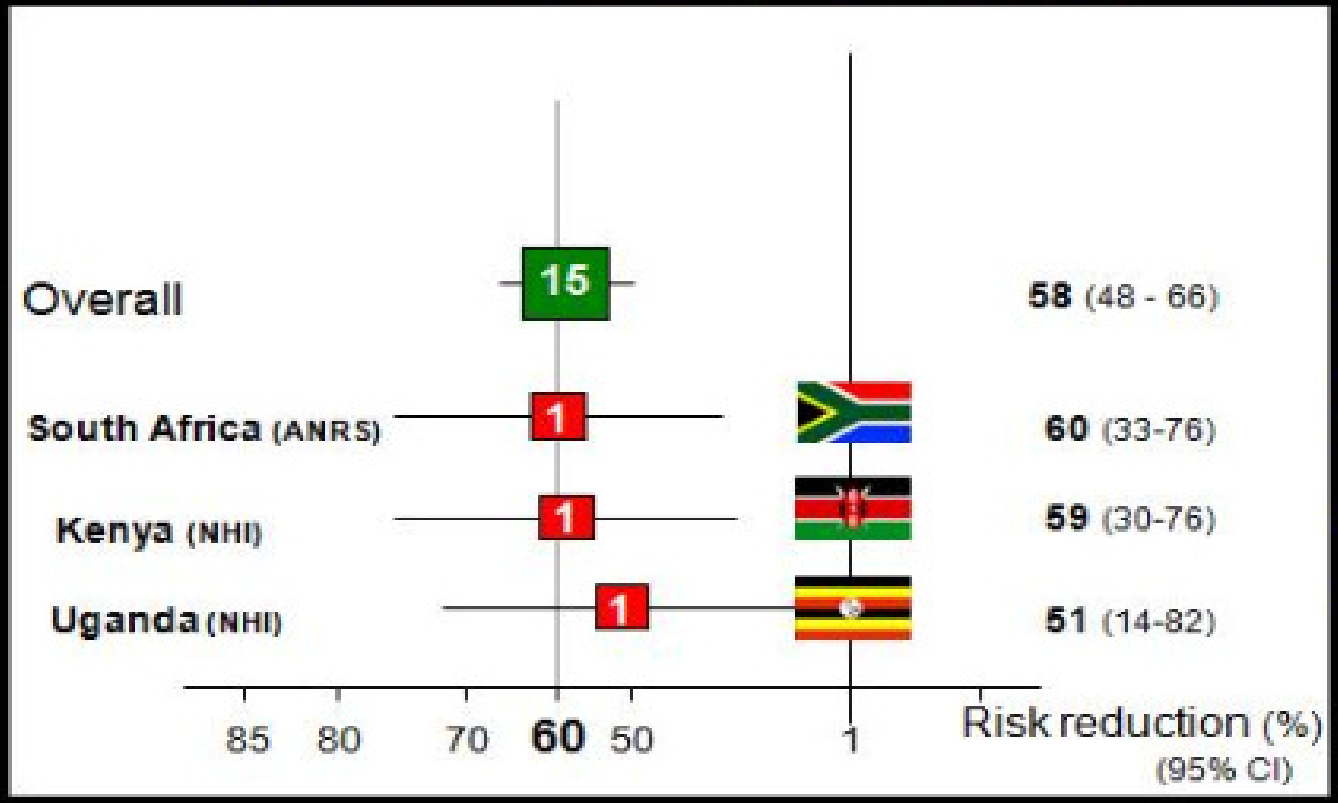
Impact of MC on HIV : Evidence from observational studies and RCTs



Weiss et al.
AIDS 2000, 14:2361-70

Auvert et al.
PLoS Med 2005[11]: e298.2006

Bailey et al.
Lancet 2007; 369: 643–56

Gray et al.
Lancet, 2007, 657–66

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Medical Male Circumcision for MSM?

- Overall probably not effective
- Some people might benefit
  - Men who are exclusively penetrative
  - Bisexual men
- Obviously MMC wont prevent anally acquired HIV
- Will protect men who are at risk for vaginal acquisition of HIV but sometimes also have sex with men
- Acceptability for gay-identified MSM?

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Suggested Approach to MMC

- MMC should be actively promoted and offered to all men who have sex with women, regardless of whether or not they also have sex with men.

- The potential benefits of MMC should be discussed, and the procedure actively promoted and offered to all MSM who report predominantly insertive sexual behaviour.

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Behavioural Prevention Strategies for HIV

- Decreasing partner numbers
- Sero adaptive behaviours - MSM
  - Sero sorting
  - Sero positioning
- Addressing substance use and abuse
- Normalising masturbation
- Non-penetrative sex – normalising

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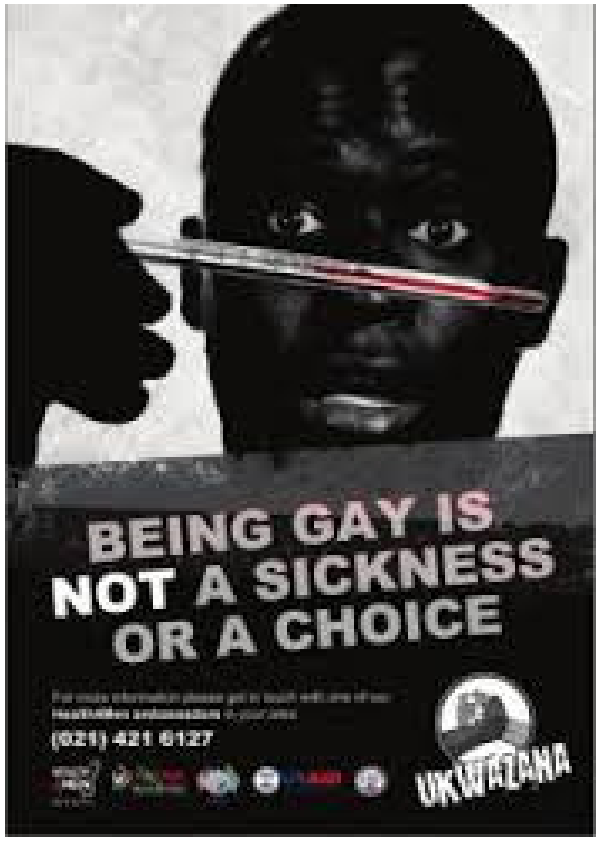
Depression and Anxiety

- Result of living in a criminalised or stigmatised environment
- Heteronormativity
- Self-worth and self esteem



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Challenges with harm reduction programmes

- Lack of community knowledge about the benefits of harm reduction services.
- Fear of legal prosecution
  - Needle exchange is illegal in many settings
  - One participant arrested with H4M IDU pack
- Lack of detox and rehab referral services.
- Lack of sponsored OST.
- High mental health disease burden.
- Difficulty employing and managing people with active addiction lifestyle or in recovery as outreach workers.

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Harm Reduction Services for KP who use recreational drugs

- HIV, Hepatitis B and C screening
- Linkage to in-house care if positive (integrated services)
- Counselling
- Harm reduction packs
  - IDU packs (Including needle and syringe exchange)
  - Non-IDU packs
- Opioid substitution therapy
- Condoms and lubricant
- IEC materials and helpline details
- Treatment of drug-use complications
- Linkage to detox and rehabilitation services

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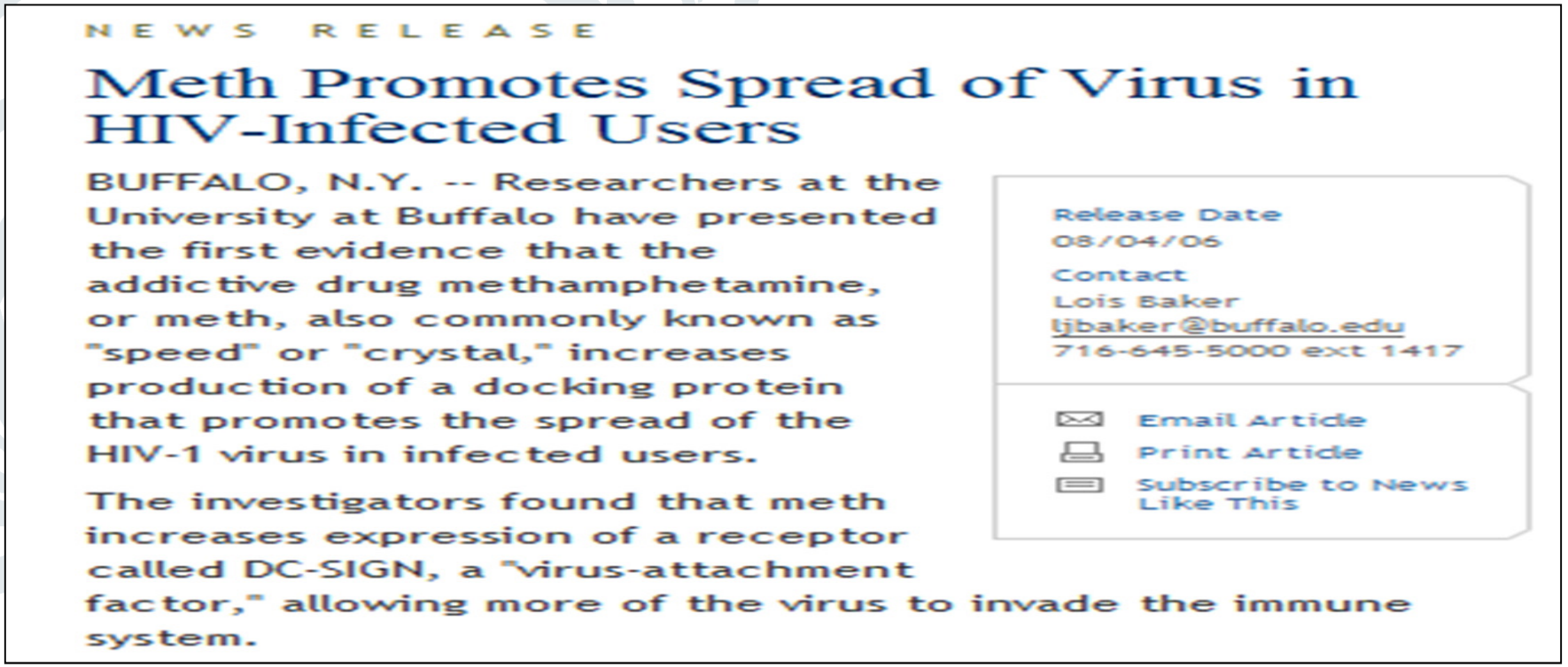
Crystal Meth and HIV Transmission



NEWS RELEASE

Meth Promotes Spread of Virus in HIV-Infected Users

BUFFALO, N.Y. -- Researchers at the University at Buffalo have presented the first evidence that the addictive drug methamphetamine, or meth, also commonly known as "speed" or "crystal," increases production of a docking protein that promotes the spread of the HIV-1 virus in infected users.

The investigators found that meth increases expression of a receptor called DC-SIGN, a "virus-attachment factor," allowing more of the virus to invade the immune system.

Release Date
08/04/06

Contact
Lois Baker
ljbaker@buffalo.edu
716-645-5000 ext 1417

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- Up regulates receptors (attachment factors on cells)
- Makes cells more susceptible to HIV infection

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Sexual Violence against Men

Common:

- Victimisation Prevalence 9.5%, (n=162, 95% CI 8.0-11.0)
- 3.3% (n=50, 95% CI 2.5-4.1) orally or anally raped
- Prison obvious (notorious) setting

Community MSM more likely to experience assault (aOR =7.34; CI 4.3-12.5)

- MSM more likely to report more severe violence.
- Intimate partner violence high
- 'Prevalence of rape victimisation reported by MSM in this study is comparable to prevalence of rape victimisation reported by SA women.

Dunkle KL et al. Prevalence of Consensual Male-male Sex and Sexual Violence, and Associations with HIV in South Africa. Plos Med 10(6): e1001472

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Invasive *Neisseria meningitidis*

- Usually not sexually transmitted.
- Outbreaks amongst MSM
  - Serogroup C Neisseria meningitidis
  - Sexually transmitted
  - HIV positive
  - ‘Clusters’
  - Serious- Meningococcemia, Meningitis.
- Vaccination

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SUMMED UP

TO DISCLOSE OR NOT TO DISCLOSE
For anyone coming to grips with their HIV positive status, choosing to be open to friends, family or anyone else can be a tricky decision. Riaan Norval looks at how to balance honesty with protecting your right to privacy.

[health]

TO DISCLOSE OR NOT TO DISCLOSE

Thu, 27 June 2013

Whether you've only just learned about your HIV positive status and it's still fresh news that you are beginning to absorb or it's something you have been living with for a while, there are bound to be many situations in your life in which you will be faced with the decision of whether or not to disclose your HIV status.

In a number of circumstances you will find yourself trying to balance honesty with protecting your right to privacy.

Whom do you feel you need to tell? Is there someone you want to tell, but aren't sure what or how much to say? Is there anyone you feel that you must tell, like a spouse, a partner, or perhaps someone whom you've been dating? What about informing any sex partners you've been with about your status?

This is a difficult decision to make because disclosure (or not disclosing) can have significant consequences. As with so many of the important life decisions, there are no absolute answers that are right for everyone. It

MOST READ | MOST EMAILED | MOST COMMENTED

AUSSIE RUGBY HUNK NUDE PICS GO VIRAL
BOND'S Q COMES OUT AS GAY
UPSET OVER PRETORIA PRIDE CLASH WITH PEOPLE'S PRIDE
MUGABE SLAMS SOUTH AFRICA OVER GAY RIGHTS
YOU GET GAY BACKPACKERS, TOO
JOBURG PRIDE EMBROILED IN VODKA BOYCOTT CONTROVERSY
SA-BORN NEW ZEALANDER WINS MR GAY WORLD

HEALTH 4MEN connect

Questions & Answers

I got a mole in my penis shoud I be comsend
Read answer

Hey..... I once had this burning sensation wen I peed and when my penis got hard it would hurt..... so I went to see a GP and was given a shot and medication and after the shot I was

ANOVA HIV Clinicians Discussion eForum; South Africa

Email list

Clinicians in South Africa with interest in HIV

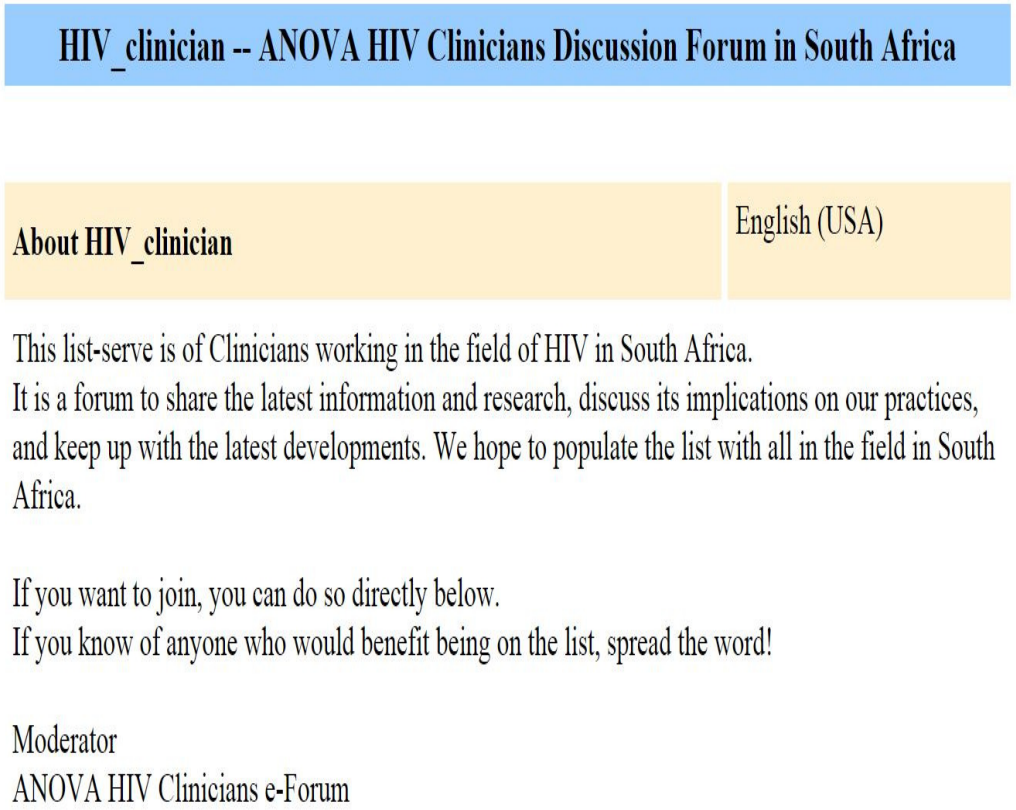
Register online

http://lists.anovahealth.co.za/mailman/listinfo/hiv_clinician

Or send me email at

moderator@anovahealth.co.za

Daily, 2 emails- Breaking News, Published Articles



HIV_clinician -- ANOVA HIV Clinicians Discussion Forum in South Africa

About HIV_clinician	English (USA)

This list-serve is of Clinicians working in the field of HIV in South Africa.
It is a forum to share the latest information and research, discuss its implications on our practices, and keep up with the latest developments. We hope to populate the list with all in the field in South Africa.

If you want to join, you can do so directly below.
If you know of anyone who would benefit being on the list, spread the word!

Moderator
ANOVA HIV Clinicians e-Forum

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Thank You

SA HIV Clinicians Society

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