

# A SWOT ANALYSIS OF HEALTH SERVICE ACCESS BY MEN WHO HAVE SEX WITH MEN IN SOUTH AFRICA: LESSONS FOR HIGHER EDUCATION INSTITUTIONS

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## **ABSTRACT**

Few interventions to address heteronormativity in health education and practice exist within South Africa's Higher Education Institutions (HEIs). We conducted a strengths, weaknesses, opportunities and threats (SWOT) analysis of programmes that enhanced the competency of health workers with respect to men who have sex with men (MSM) and the MSM-focused HIV response in South Africa to develop recommendations for similar interventions within HEIs. We found that a combination of political will, MSM community mobilisation, appropriate training approaches, and dedicated funding have enabled the up-scale of HIV-related services for MSM. The implications of our analysis suggest that support from HEI management, student mobilisation, sensitisation training, dedicated financing, and mechanisms to address discrimination would

facilitate expansion of practices at HEIs to include the health and wellbeing of sexual minorities.

**Keywords:** heteronormativity, sensitisation training, men who have sex with men, lesbian gay bisexual transgender, higher education institutions

## **BACKGROUND**

The South African Constitution highlights freedom from discrimination on the basis of sexual orientation and gender (South African Government 1996). However, many people who do not conform to heterosexual norms experience stigma, discrimination and exclusion in community and healthcare settings (Scheibe et al. 2016; Lane et al. 2008; Rispel et al. 2011; Jobson et al. 2013). Culturally insensitive and inappropriate health services contribute to the relatively higher burden of sexual and reproductive health conditions, including HIV, that affect lesbian, gay, bisexual and transgender (LGBT) people in South Africa (Seale 2009; Rispel and Metcalf 2009). Multiple studies have shown how the HIV burden among men who have sex with men (MSM) is significantly higher than among men in the general population (Lane et al. 2009; Burrell et al. 2010; Baral et al. 2007; Sandfort, Reddy, and Nel 2015). HIV prevalence among MSM aged 18 years and older in Cape Town, Johannesburg and Durban is estimated to be 22 per cent, 27 per cent and 48 per cent respectively (Cloete et al. 2014). In contrast, HIV prevalence among men aged 15 years and over in the general population of these cities is estimated to be 5 per cent, 14 per cent and 19 per cent respectively (Human Sciences Research Council 2014). No representative HIV prevalence surveys have been done among lesbian and bisexual women and transgender people in South Africa ((Desmond Tutu HIV Foundation 2011a; Daly 2015; Stevens 2012). However, high levels of social exclusion, violence, rape and barriers to health services contribute to HIV risk among lesbian and bisexual women and transgender people (Desmond Tutu HIV Foundation 2011a; Sandfort et al. 2015; Sandfort et al. 2013). Access to healthcare for LGBT individuals is enhanced by welcoming clinical environments that are based on culturally competent healthcare providers (Scheibe et al. 2016; Rebe et al. 2013). However, LGBT clinical competency and welcoming clinical environments are limited in South Africa.

### **Medical practice and health outcomes**

The heterosexual and reproductive foci of health professional education and practice contribute to social and structural factors that increase vulnerability to HIV infection among sexual minorities. There is limited integration of LGBT health cultural competency training in medical schools and professional development programmes for healthcare professionals (University of California San Francisco 2015; Müller 2013). Thus, health education and practice in South

Africa are largely heteronormative. Specific health risks and issues that affect people from sexual minority groups are rarely included in training or appropriately managed in practice (Scheibe et al. 2011). As a result, sexual minorities experience and fear discrimination from healthcare workers when accessing health services, and this has been identified as a barrier for LGBT individuals to access these services (Lane et al. 2008; Rispel et al. 2011).

Until recently, neither HIV prevention interventions nor related tools existed to address the specific health needs and sexual risk reduction of LGBT people (Desmond Tutu HIV Foundation 2011a). Most safer sex education has focused almost exclusively on penile-vaginal intercourse and few health providers are able to identify and correctly manage anal sexually transmitted infections, even though the sexual transmission risk of HIV infection is highest through unprotected anal intercourse (Rebe et al. 2013; Desmond Tutu HIV Foundation 2011a; Baggaley, White, and Boily 2010). A survey done by Müller et al. in 2013 at one of South Africa's largest health science faculties found that very little LGBT health-related content was included in the training for doctors, and none in the training of allied health professionals. Further, opportunities for students to challenge their personal attitudes and beliefs towards LGBT people were not provided and relevant health topics (including safer sex, mental health and substance use) were not addressed during under graduate training (Müller 2013).

Unsupportive clinical environments frequently contribute to the concealment of sexual behaviour and identity (Rebe et al. 2013). Delaying or not seeking medical services, or concealing sexual health needs within clinical encounters, increases the likelihood of negative health outcomes for infectious diseases that require medical management, including elevating the risk of transmission to other people (Ayala 2014). For example, in the context of HIV, the likelihood of contracting an opportunistic infection, including tuberculosis, or developing AIDS is greatly increased when antiretroviral therapy (ART) is not initiated at an appropriate time (National Institute of Allergy and Infectious Diseases 2015). Similarly, health outcomes are poorer when individuals receive incorrect medical diagnosis and management from clinicians who do not consider, or who are not informed about, appropriate approaches to caring for non-heterosexual clients (World Health Organization 2014). Misdiagnosis and clinical mismanagement are more likely among health workers who have not received LGBT competency training, particularly before entering medical services. Training enables the conduct of appropriate sexual histories and examinations, including discernment of differential diagnoses and subsequent management of common conditions affecting people who engage in a range of sexual practices (Müller 2013).

## **Focus on MSM**

Increasingly, public health efforts have focused on reducing HIV infection among MSM in South Africa, due to local evidence that links HIV transmission between MSM to broader patterns of sexual transmission in the general population (SACEMA 2009). A wide range of health system strengthening initiatives have been implemented to improve HIV prevention and care for MSM, ranging from medical education and service delivery to efforts to foster enabling environments (South African National AIDS Council LGBTI Sector 2011; University of California San Francisco 2015; Rebe et al. 2013). The successes, challenges and lessons learnt from these initiatives may improve the health and wellbeing of MSM and LGBT people in other contexts.

## **Higher Education Institutions as entry points**

Few interventions to reduce HIV risks among MSM and other sexual minorities have occurred within Higher Education Institutions (HEIs) to date (Brink 2012). Yet, there are high levels of stigma, discrimination and exclusion of MSM and LGBT people at HEIs (NACOSA and HEAIDS 2014). HEIs may therefore be a particularly potent point of intervention. Students at HEIs could either be exposed to environments that support sexual diversity or perpetuate discrimination. Training for students in the faculties of health sciences and other disciplines could either equip them to screen for and manage issues affecting LGBT people, or produce professionals who are not competent to identify and correctly manage the health and social issues affecting sexual minorities.

Building clinical skills and sensitivity among healthcare workers early in their professional education has the potential to institutionalise cultural competency with regard to working with sexual minorities (Van der Elst et al. 2013). In turn, codifying clinical education within one setting could then offer an opportunity for replication in other settings, thereby shifting the workforce over time.

## **AIM**

In this article, we aimed to review work in the field of HIV prevention and care for MSM in South Africa to identify lessons that could be applicable to address heteronormativity and homophobia that affect LGBT students at HEIs in South Africa and the region.

## **METHODS**

### **Design**

We conducted a rapid strengths, weaknesses, opportunities and threats (SWOT) analysis of efforts to address heteronormativity in health professional education and practice, focusing on MSM and HIV in South Africa. SWOT is an analytical technique that is used to review a programme's strengths, weaknesses, opportunities and threats to inform planning (Woratanarat and Woratanarat 2012). SWOT has been used to assess and develop recommendations to improve health worker training and public health interventions in a range of settings (Wazir, Shaikh, and Ahmed 2013; Woratanarat and Woratanarat 2012; Hande 2014).

We defined a set of contextually relevant, best-practice interventions that could be used to address heteronormativity in health education and practice. Inclusivity of sexually diverse people, and sensitive and competent management of health issues affecting them, were viewed as priority factors to assess heteronormative health education and practice. Interventions that focused on the World Health Organization's health system building blocks (services, workforce, information, products and technology, financing, leadership and governance) were included (see Figure 1) (World Health Organization 2007). Published and non-published literature on MSM-focused health education and practice done after 2008 were used to inform the analysis. Thereafter, we assessed the apparent strengths of completed and ongoing work in the field of MSM and HIV in South Africa that may provide a strategic advantage to address heteronormativity. Strategic advantages included elements or activities that we perceived would account for favourable outcomes or impact of interventions. Characteristics of programmes that we perceived to be disadvantageous were categorised as weaknesses, including elements that contributed to poor health outcomes among MSM. Elements that could be capitalised upon to further enhance efficiencies, coverage or likely impact were viewed as opportunities. Threats included elements that we thought could potentially have a negative effect on addressing heteronormativity. We reviewed and discussed the data and used our insights and experiences in the field to draw out lessons that could be applicable to HEIs.

## **FINDINGS**

### **Strengths**

Between 2008 and 2014, the availability of MSM-focused HIV prevention services in South Africa increased, as shown in Table 1. This has resulted in greater distribution of condoms and

Service delivery	Health workforce	Information	Medical products	Financing	Leadership/governance
<ul style="list-style-type: none"> <li>• Minimum package of services (condoms, lubricant, behavior change interventions, HCT, STI screening and referral)</li> <li>• Includes interventions to address violence; substance use &amp; mental health</li> <li>• Enabling environments</li> <li>• Developmental approach with CSOs</li> </ul>	<ul style="list-style-type: none"> <li>• Sensitisation training</li> <li>• Competency training</li> <li>• Mentorship</li> <li>• Support tools</li> <li>• Employment of MSM</li> </ul>	<ul style="list-style-type: none"> <li>• MSM surveillance</li> <li>• MSM specific targets for HIV response</li> </ul>	<ul style="list-style-type: none"> <li>• Condoms</li> <li>• Lubricant</li> <li>• Hepatitis B screening, vaccination</li> <li>• Sexual reproductive health &amp; rights</li> </ul>	<ul style="list-style-type: none"> <li>• International &amp; donor funding</li> <li>• National funding</li> <li>• Private fee-for service</li> </ul>	<ul style="list-style-type: none"> <li>• National strategies include MSM</li> <li>• National leadership supportive of MSM</li> <li>• Effective coordination</li> <li>• MSM led advocacy</li> <li>• Appropriate, local guidelines</li> </ul>

**Figure 1:** List of best practices to enhance health education and practice around HIV among MSM

lubricant, from just over 150 000 condoms in 2008 to over 3 million in 2013. In 2013, approximately 19 000 MSM were reached with behaviour change interventions, compared to just under 3 000 the previous year (University of California San Francisco [UCSF] 2015). Reported HIV tests completed by MSM increased from just over 600 in 2008 to about 9000 in 2013 (UCSF 2015). Several civil society organisations provided MSM-focused services in major metropolitan areas during this time. In 2014, there were 1067 clinical and non-clinical sites in the South African Department of Health's High Transmission Areas (HTA) programme, which provides HIV prevention services for key populations, including MSM (National Department of Health 2015).

During this time, the capacity of health workers to provide competent health services in supportive environments has improved (Scheibe et al. 2011). This is demonstrated by studies that show health workers who attended LGBT competency training had increased knowledge around common health problems affecting MSM and had improved capacity to take appropriate sexual histories and examinations (ICAP Columbia University 2013). Health worker sensitisation and clinical competency training (including the development of curricula, tools, train-the-trainer and mentorship programmes) have been implemented in almost all provinces in the public and non-profit sector (Anova Health Institute 2010; Desmond Tutu HIV Foundation 2011b; National Department of Health and South African National AIDS Council 2013).

Recently, a triangulation process was conducted to review all available data and expert

opinion on MSM and HIV in South Africa between the years 2008 and 2013, and as a result, several recommendations were outlined to improve the country's response to HIV prevention for MSM (UCSF 2015). These recommendations included increased access to evidence-based prevention interventions; the provision of services beyond metropolitan areas; capacity development of MSM community based organisations; efforts to address the social and structural factors driving the HIV epidemic among MSM (including stigma and discrimination), and improvements in the collection and usage of strategic information (UCSF 2015). Further, in 2015, a multi-city integrated bio-behavioural survey with MSM commenced to assess HIV prevalence, risk practices and service utilisation. This survey will provide additional strategic information to inform the public health response and provide insights into the accessibility and acceptability of health services for MSM. Increased investments into MSM programmes have enabled this work and the majority of financing has come from international donors, and more recently from government sources (Guthrie et al. 2015).

South African leadership and stewardship for increased LGBT health competency in health professionals has been made possible by a protective constitution. The national HIV strategic plan defines MSM as a key population in need of specific services, and the development of an LGBT sector within the South African National AIDS Council also contributed (South African National AIDS Council 2011; South African Government 1996; South African National AIDS Council LGBTI Sector 2011). Further, draft operating guidelines for HIV programmes for key populations, including MSM, have also been developed (Department of Health and SANAC 2012). These guidelines recommend health professional training to ensure effective implementation and improved HIV outcomes for LGBT individuals across the country.

**Table 1:** Strengths of MSM response to improve access services and foster an enabling environment

Building block	Key findings from strengths analysis
Services	<ul style="list-style-type: none"> <li>• Increasing access to package of services appropriate for MSM, largely through MSM focused services implemented by civil society organisations</li> <li>• High transmissions area (HTA) programme increasing in size (1067 sites in 2015)</li> <li>• MSM focused information and behaviour change information around key sexual health and wellness topics using various modalities (print, online)</li> <li>• Government funded pre-exposure prophylaxis for MSM in selected clinics planned to launch in 2017</li> </ul>
Human resources	<ul style="list-style-type: none"> <li>• Informal development of referral networks within locales and provinces</li> <li>• Identification of advocates and allies to champion inclusive health services within organisations and health departments</li> <li>• Health worker sensitisation &amp; competency training: increasing coverage, across all provinces</li> <li>• NDOH and PDOH buy-in &amp; support</li> <li>• MSM employed as peer educators, nurses &amp; doctors</li> <li>• STI training in some provinces including elements of sensitisation</li> </ul>

Building block	Key findings from strengths analysis
Information	<ul style="list-style-type: none"> <li>• Good evidence base on HIV burden among MSM</li> <li>• Programmatic data being collected through current programmes</li> <li>• Data triangulation ongoing</li> <li>• IBBS ongoing to address gaps</li> </ul>
Products	<ul style="list-style-type: none"> <li>• Condoms and lubricant access availability increasing</li> <li>• HIV and STI test kits widely available</li> <li>• Antiretroviral therapy available</li> </ul>
Finance	<ul style="list-style-type: none"> <li>• Increasing funding for MSM-focused projects</li> <li>• Limited government funding leads to partnerships for commodities</li> </ul>
Leadership	<ul style="list-style-type: none"> <li>• SANAC LGBTI sector formed</li> <li>• NDOH developing a Key Population HIV Framework</li> <li>• Increased commitment from provinces with limited MSM services</li> <li>• Minimum standards for quality assurance developed</li> </ul>

\*National Department of Health (NDOH), Provincial Department of Health (PDOH), Integrated Biological and Behavioural Survey (IBBS), South African National AIDS Council (SANAC)

## Weaknesses

An overview of weaknesses is provided in Table 2. Coverage provided by MSM programmes has increased in the last ten years, but interventions are largely biomedical in focus and there is sub-optimal coordination – with few, if any, MSM-focused services available in smaller urban areas (UCSF 2015). Service quality is not routinely measured and anecdotal reports of stigma and discrimination by health workers towards MSM are ongoing (Rispel et al. 2011; Lane et al. 2008; ICAP Columbia University 2012). Currently, there is no well-functioning mechanism to report incidents of discrimination or human rights violations within the health system. Few of the HTA programme sites employ MSM-peers as outreach workers and an MSM indicator was only introduced in 2014 (National Department of Health 2014). Furthermore, access to condoms, lubricant and HIV counselling and testing is not universal (Batist et al. 2013; Scheibe et al. 2016; Tucker et al. 2013; Cloete et al. 2014).

Access to post-exposure prophylaxis for accidental sexual exposure is not widely available (UCSF 2015). Most MSM-focused health worker training is in-service; few universities include training around MSM issues in their undergraduate curricula (Müller 2013). Systems to collect, analyse and use strategic information to improve programming for MSM is limited at the local level, with few municipalities or districts having data on MSM HIV prevalence and risk practices, and MSM-focused services (UCSF 2015). Guidelines that relate to the minimum package of services for MSM have not been finalised or implemented.



**Table 2:** Weaknesses of MSM response to improve access services and foster an enabling environment

Building block	Key findings from the weakness analysis
Services	<ul style="list-style-type: none"> <li>• Varying quality of services, with limited implementation of quality assurance interventions after sensitisation and competency training</li> <li>• Mechanisms to report discrimination/violations not established</li> <li>• HTA programme not reaching MSM per se</li> <li>• Post-exposure not fully accessible for HIV exposure</li> </ul>
Human resources	<ul style="list-style-type: none"> <li>• Very limited inclusion of MSM issues in under graduate training of health and other professionals</li> <li>• Mentorship and ongoing learning opportunities limited</li> <li>• The limited number of MSM-experienced programme staff contributes to high staff turn-over due to 'head hunting' practices, undermining continuity of programmes</li> <li>• Limited changes in pre-service training</li> <li>• High staff turn-over, and staff rotation through various divisions within the public health sector</li> </ul>
Information	<ul style="list-style-type: none"> <li>• Local level assessments not widely done</li> <li>• Strategic information is not fully used to tailor programmes</li> </ul>
Products	<ul style="list-style-type: none"> <li>• Commodity coverage limited</li> </ul>
Finance	<ul style="list-style-type: none"> <li>• Limited coordination</li> <li>• Largely international donor support – limited govt. funds</li> </ul>
Leadership	<ul style="list-style-type: none"> <li>• National documents and guidelines that cover MSM-related issues need to be developed and implemented</li> </ul>

## Opportunities

An overview of opportunities is provided in Table 3. The MSM triangulation process highlighted that by the end of 2013 it was too early to assess the impact of the HIV response and, despite limited data, recommended the need for increased investments and scale-up of programmes for MSM (UCSF 2015). Service implementation has resulted in the generation of knowledge, expertise and models of care (Rebe et al. 2013). Findings from ongoing pre-exposure prophylaxis (PrEP) studies could inform PrEP roll-out for MSM, which is planned in selected sites in 2017 (personal discussions with investigators from the Anova Health Institute and the Desmond Tutu HIV Foundation). Knowledge could be shared and transferred to the public health system through in-service learning and also by incorporating lessons and priority health and rights issues into pre-service training of health workers.

Existing government training structures could be used as conduits for MSM-related training and inclusion of other health and rights issues affecting other key populations (i.e. sex workers and people who use drugs) could increase dissemination efficiency (National Department of Health and South African National AIDS Council 2013). Inclusion of training around these issues could be part of staff introductory training. Service delivery models that have proven to be feasible and effective could be scaled-up. MSM-focused programmes include monitoring and evaluation activities and this data could be forwarded to local authorities, and

enhance local responses. The use of standard indicators would improve monitoring of other outcomes across a variety of programmes. The existing policy and local and global commitments to improving the health and rights of MSM, supported by strategic information, could be used to motivate and increase service coverage and address stigma and discrimination towards MSM where it still exists. Existing government funding mechanisms could be used for MSM-specific programmes and include mechanisms to integrate MSM-services into mainstream services.

**Table 3:** Opportunities to improve the MSM response to improve access services and foster an enabling environment

Building block	Key findings from opportunity analysis
Services	<ul style="list-style-type: none"> <li>• Possibility to capitalise on existing policy &amp; commitments</li> <li>• Multiple funded partners and experience to inform process</li> <li>• Increased focus on anal sex; generally, could increase related education, de-stigmatisation, and sexual health exams</li> </ul>
Human resources	<ul style="list-style-type: none"> <li>• Institutionalisation of training on issues affecting MSM and other key populations could increase dissemination efficiency</li> <li>• Employing MSM staff increase visibility</li> </ul>
Information	<ul style="list-style-type: none"> <li>• Expertise &amp; infrastructure exists to implement surveillance</li> <li>• Opportunity to use programme data to inform services</li> <li>• Pre-exposure prophylaxis and treatment as prevention could be tested</li> </ul>
Products	<ul style="list-style-type: none"> <li>• Increasing commodity access could be used to provide other services</li> </ul>
Finance	<ul style="list-style-type: none"> <li>• Key population funding likely to increase, plan accordingly</li> <li>• Conditional grant opportunity to strengthen 'mainstreaming'</li> <li>• Provincial HAST business plans essential for sustainability</li> </ul>
Leadership	<ul style="list-style-type: none"> <li>• Use current pressure on provinces to advance the agenda</li> <li>• Local data &amp; experience exist and can be used for policy</li> <li>• Experts to act as policy entrepreneurs and drivers of change</li> </ul>

\*HIV/AIDS, STIs and TB (HAST)

## Threats

The gains made in improving the rights and health of MSM in South Africa could be negatively influenced by several factors. Additional focus on MSM may contribute to unintended negative consequences for these men, including further stigmatisation on the basis of their sexual practices or identity (McAdams-Mahmoud et al. 2014). Approaches that do not take the diversity of MSM sub-groups into account (i.e. addressing the needs of MSM youth, or mainstreaming messages and services around anal sex to access non-gay identifying MSM) may limit the effectiveness of efforts (UCSF 2015).

Increased funding that does not strengthen community health systems and particularly MSM 'grass roots' organisations, could negatively affect MSM community mobilisation and the sustainability of responses (Rua 2013). The over reliance on external donors to support

programmes for MSM runs the risk of insufficient preparation for government to continue to support these programmes when donor support stops. High level decision makers who may not be aware of the rights and health issues affecting MSM may not prioritise these issues, limiting MSM to reach their potential and to address stigma and discrimination on the basis of sexual practices or gender identity.

**Table 4:** Threats to the MSM response to improve access services and foster an enabling environment

Building block	Key findings from threat analysis
Services	<ul style="list-style-type: none"> <li>• MSM-focused services may cause further stigmatisation</li> <li>• Effectiveness limited unless diversity of MSM sub-groups taken into account</li> <li>• Mainstreaming may not be effective, unless appropriate</li> <li>• Larger organisations threaten 'grassroots' organisations</li> </ul>
Human resources	<ul style="list-style-type: none"> <li>• Risk of reinforcing notion of MSM as 'vectors' of HIV</li> </ul>
Information	<ul style="list-style-type: none"> <li>• Documentation of high HIV burden may increase discrimination</li> </ul>
Products	<ul style="list-style-type: none"> <li>• Inconsistent supply threatens ability to prevent HIV infections</li> </ul>
Finance	<ul style="list-style-type: none"> <li>• Reliance on external donors threatens sustainability</li> <li>• High cost intensive programmes limit coverage</li> </ul>
Leadership	<ul style="list-style-type: none"> <li>• Multiple competing agendas</li> <li>• Constitution &amp; Rights fragile</li> <li>• Limited political support threatens MSM programme sustainability</li> </ul>

## LIMITATIONS

This SWOT analysis was not an exhaustive analysis of MSM health professional competency training, or of MSM programme interventions in South Africa. The analysis was grounded in our expertise and opinions working with MSM and LGBT communities and health issues in South Africa. We have a range of experience in working with MSM in South Africa, from biomedical research, community mobilisation, policy development and health worker training. However, none of us work as clinicians within the South African government's public health sector, nor do we routinely conduct medical consultations. We acknowledge that our perspectives as well-informed observers may not have fully captured the nuances and competing priorities public sector clinicians and other health care personnel face with MSM and other patients who rely on this system for care. Nonetheless we are confident this analysis is sufficiently grounded in relevant scholarship, methodologically rigorous observation, and our own professional experiences with MSM and the South African health system to be of value in informing health policy and practice with respect to South Africa's MSM population in HEIs and more generally.

## LESSONS FOR HEIS

HEI health systems could be good entry points to make HEIs supportive of the rights and health of LGBT people. Furthermore, national policy and commitments can be, and should be, applied

to HEIs. The tools that have been developed to increase the sensitivity and competency of health care workers in South Africa are valuable resources that could be adapted and used within the context of HEIs. The inclusion of sexual minority health and rights issues within undergraduate and post-graduate nursing, counselling and doctor training is an important intervention for sustainable change. Highlighting the need for the inclusion of this training within relevant curricula could assist to bring the health and rights issues affecting LGBT people at HEIs under the spotlight, and provide a window of opportunity for reform. Implementing this training would result in a new generation of health care providers who are better equipped to assess and manage the health and related issues affecting their patients.

Strategic initiatives to sensitise health workers, HEI staff and other stakeholders that could enable or threaten efforts to foster LGBT-supportive environments are needed. The collection of strategic information to monitor instances of stigma and discrimination and inappropriate or incompetent health service delivery at HEIs should occur. This information should be used for advocacy purposes and to measure progress HEIs are making to support gender diversity and the issues affecting sexual minority groups. Sustainable financing is needed to increase access to services and to support efforts aimed at fostering supportive environments for LGBT people at HEIs. It is essential for the LGBT community at HEIs to be engaged and mobilised for programmes to be effective.

## CONCLUSION

The MSM response in South Africa appears to be moving in the right direction. Evidence suggests that access to culturally appropriate services for MSM and LGBT people is increasing, and has followed concerted efforts to bring about change. Lessons identified through this SWOT analysis could be applicable to improving the health and wellbeing of LGBT people at HEIs in South Africa and beyond.

## REFERENCES

- Anova Health Institute. 2010. *From top to bottom. A sex-positive approach for men who have sex with men. A manual for healthcare providers*. Johannesburg: Anova Health Institute.
- Ayala, George. 2014. HIV Treatment cascades that leak: Correlates of drop-off from the HIV care continuum among men who have sex with men worldwide. *Journal of AIDS & Clinical Research* 05. doi:10.4172/2155-6113.1000331
- Baggaley, Rebecca, F., Richard G. White and Marie-Claude Boily. 2010. HIV transmission risk through anal intercourse: Systematic review, meta-analysis and implications for HIV prevention. *International Journal of Epidemiology* 39(April): 1048–63. doi:10.1093/ije/dyq057
- Baral, Stefan, Frangiscos Sifakis, Farley Cleghorn and Chris Beyrer. 2007. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: A systematic review. *PLoS Medicine* 4(12): e339. doi:10.1371/journal.pmed.0040339

- Batist, Elizabeith, Benjamin Brown, Andrew Scheibe, Stefan D. Baral and Linda-Gail Bekker. 2013. Outcomes of a community-based HIV-prevention pilot programme for township men who have sex with men in Cape Town, South Africa. *Journal of the International AIDS Society* 16(4) (Suppl 3): 1–7. doi:10.7448/IAS.16.4.18754
- Brink, Jaco G. 2012. *An investigation of risky sexual behaviours, basic HIV knowledge and interntion to use condoms among a sample of men who have sex with men in a study community*. Stellenbosch: University of Stellenbosch.
- Burrell, Earl, Daniella Mark, Robert Grant, Robin Wood and Linda-Gail Bekker. 2010. Sexual risk behaviours and HIV-1 prevalence among urban men who have sex with men in Cape Town, South Africa. *Sexual Health* 7(2): 149–53. doi:10.1071/SH09090
- Cloete, Annalise, Likeness C. Simbayi, Thomas Rehle, S. Jooste, M. Mabaso, L. Townsend, Y. Ntsepe, et al. 2014. *The South African Marang men's project: HIV bio-behavioural surveys using respondent-driven sampling conducted among men who have sex with men*. Cape Town: HSRC Press.
- Daly, Felicity. 2015. *Claiming the human right to health for women who have sex with women through South Africa's National Strategic Plan on HIV and STIs. Policy brief*. Durban: HEARD.
- Department of Health and SANAC. 2012. *Operational guidelines for HIV, STIs and TB programmes for key populations in South Africa. Final Draft*. Pretoria.
- Desmond Tutu HIV Foundation. 2011a. Key populations, key solutions. A gap analysis for key populations and HIV in South Africa. *Report*. Pretoria: South African National AIDS Council.
- Desmond Tutu HIV Foundation. 2011b. *Men who have sex with men: An Introductory guide for health workers in Africa*. <http://www.desmondtutihivfoundation.org.za/presentation/msmmanual/>
- Guthrie, T., T. Ryckman, S. Soe-Lin and R. Hecht. 2015. Consolidated spending on HIV and TB in South Africa (2011/12 – 2013/14). Draft Report. Pretoria: Results for Development.
- Hande, S. 2014. Strengths weaknesses opportunities and threats of blended learning: Students' perceptions. *Annals of Medical and Health Sciences Research* 4(3): 336. doi:10.4103/2141-9248.133455
- Human Sciences Research Council. 2014. *HIV prevalence among adults (15 years and above). Additional analysis of the 2012 national household survey*. Cape Town: HSRC.
- ICAP Columbia University. 2012. *Rapid situational report. HIV prevention services for men who have sex with men and capacity building assistance for high risk, underserved populations in South Africa*. Pretoria.
- ICAP Columbia University. 2013. *ICAP key populations program data financial year 1–3*. Pretoria: ICAP Columbia University.
- Jobson, Geoffrey, Glenn de Swardt, Kevin Rebe, Helen Struthers and James McIntyre. 2013. HIV risk and prevention among men who have sex with men (MSM) in peri-urban townships in Cape Town, South Africa. *AIDS and Behavior* 17(Suppl 1) (May): S12–22. doi:10.1007/s10461-012-0328-5
- Lane, T., Thomas Mogale, Helen Struthers, Jame McIntyre and Susan M. Kegeles. 2008. 'They see you as a different thing': The experiences of men who have sex with men with healthcare workers in South African Township Communities. *Sexually Transmitted Infections* 84(6): 430–33. doi:10.1136/sti.2008.031567
- Lane, Tim, Henry Fisher Raymond, Sibongile Dladla, Joseph Rasethe, Helen Struthers, Willi McFarland and James McIntyre. 2009. High HIV prevalence among men who have sex with men in Soweto, South Africa: Results from the Soweto men's study. *AIDS and Behavior* Apr 15(3): 626–34. doi:10.1007/s10461-009-9598-y
- McAdams-Mahmoud, Ayesha Rob Stephenson, Christopher Rentsch, Hannah Cooper, Kimberly Jacob Arriola, Geoffrey Jobson, Glenn de Swardt, Helen Struthers and James McIntyre. 2014. Minority stress in the lives of men who have sex with men in Cape Town, South Africa. *Journal of Homosexuality* 61(September): 847–67. doi:10.1080/00918369.2014.870454

- Müller, Alexandra. 2013. Teaching lesbian, gay, bisexual and transgender health in a South African Health Sciences Faculty: Addressing the Gap. *BMC Medical Education* 13(January): 174. doi:10.1186/1472-6920-13-174.
- NACOSA and HEAIDS. 2014. *National student sexual health HIV knowledge, attitude and behaviour survey: Focusing on student men who have sex with men at 14 higher education institutions in South Africa*. Cape Town: NACOSA.
- National Department of Health. 2014. *High transmission area guidelines*. Pretoria: National Department of Health.
- National Department of Health. 2015. HIV prevention and treatment for people who use drugs, including people who inject drugs: Policy and programmes. In *Drug Use and HIV Pre-Conference*. Durban.
- National Department of Health and South African National AIDS Council. 2013. *Health care provision for men who have sex with men, sex workers and people who use drugs. An introductory manual for health care workers in South Africa*, ed. Ben Brown, Zoe Duby and Delene van Dyk. 1st Edition. Cape Town: National Department of Health.
- National Institute of Allergy and Infectious Diseases. 2015. Starting Antiretroviral treatment early improves outcomes for HIV-infected individuals. Press Release. *NIH News*. <http://www.niaid.nih.gov/news/newsreleases/2015/Pages/START.aspx#>
- Rebe, Kevin B., Glenn de Swardt, Helen Struthers and Jame A. McIntyre. 2013. Towards 'men who have sex with men-appropriate' health services in South Africa. *SAJHIVMED* 14(2): 52–57. doi:10.7196/SAJHIVMED.841
- Rispel, Laetitia, C. and Carol A. Metcalf. 2009. Breaking the silence: South African HIV policies and the needs of men who have sex with men. *Reproductive Health Matters* 17(33): 133–42. doi:10.1016/S0968-8080(09)33442-4
- Rispel, Laetitia, C., Carol A. Metcalf, Allanise Cloete, Julia Moorman and Vasu Reddy. 2011. You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities. *Journal of Public Health Policy* 32(Suppl 1) (s1). Nature Publishing Group: S137–51. doi:10.1057/jphp.2011.29.0
- Rua, B. 2013. *From isolation to solidarity: How community mobilization underpins HIV preventing in the Avahan India AIDS initiative*. Washin: Futures Group. doi:10.1080/10357718.2011.570244. See
- SACEMA. 2009. The modes of transmission of HIV in South Africa. *Report*. Stellenbosch: SACEMA.
- Sandfort, Theo, Vasu Reddy and Dawie Nel. 2015. Tshwane's black men who have sex with men in urgent need of HIV/AIDS services. Media Briefing. Pretoria: HSCR.
- Sandfort, Theo G. M., Linda R. M. Baumann, Zethu Matebeni, Vasu Reddy and Ian Southey-Swartz. 2013. Forced sexual experiences as risk factor for self-reported HIV infection among Southern African lesbian and bisexual women. *PLoS ONE* 8(1): 24–29. doi:10.1371/journal.pone.0053552
- Sandfort, Theo, M. Somjen Frazer, Zethu Matebeni, Vasu Reddy and Ian Southey-Swartz. 2015. Histories of forced sex and health outcomes among Southern African lesbian and bisexual women: A cross-sectional study. *BMC Women's Health* 15(1): 1–10. doi:10.1186/s12905-015-0181-6
- Scheibe, Andrew, Zoe Duby, Ben Brown, Eduard J. Sanders and Linda-Gail Bekker. 2011. Evaluation of a health care worker training program around sensitization around men who have sex with men (MSM) in Cape Town, South Africa. *6th IAS Conference on HIV Pathogenesis, Treatment and Prevention CDD132*. Rome: International AIDS Society.
- Scheibe, Andrew, Rithuli Orleyn, Anna Mia Ekström, Linda-Gail Bekker and Diane McIntyre. 2016. Social determinants of HIV among men who have sex with men in Cape Town. *Sexuality & Culture*. Springer US. doi:10.1007/s12119-016-9344-3
- Seale, Andy. 2009. Heteronormativity and HIV in sub-Saharan Africa. *Development* 52(1): 84–90. doi:10.1057/dev.2008.76
- South African Government. 1996. Constitution of the Republic of South Africa. <http://www.info>.

gov.za/documents/constitution/

- South African National AIDS Council. 2011. National Strategic Plan on HIV, STIs and TB 2012–2016. Pretoria: South African National AIDS Council. <http://www.sanac.org.za/files/uploaded/NSP8-12.pdf>
- South African National AIDS Council LGBTI Sector. 2011. *SANAC LGBTI Sector March 2011-Report*. Pretoria.
- Stevens, Marion. 2012. Transgender access to sexual health services in South Africa: Findings from a key informant survey. Cape Town: Gender DynamiX.
- Tucker, Andrew, Glenn de Swardt, Helen Struthers and James McIntyre. 2013. Understanding the needs of township men who have sex with men (MSM) health outreach workers: Exploring the interplay between volunteer training, social capital and critical consciousness. *AIDS and Behavior* 17(Suppl 1) (May): S33–42. doi:10.1007/s10461-012-0287-x
- UCSF *see* University of California San Francisco.
- University of California San Francisco. 2015. *MSM in South Africa. Data Triangulation Project*. San Francisco: University of San Francisco Global Health Sciences.
- Van der Elst, Elise M., Adrian D. Smith, Evanson Gichuru, Elizabeth Wahome, Helgar Musyoki, Nicolas Muraguri, Greg Fegan, et al. 2013. Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in Coastal Kenya. *Journal of the International AIDS Society* 16(Suppl 3): 1–9. doi:10.7448/ias.16.4.18748
- Wazir, Mohammad Salim, Babar Tasneem Shaikh and Ashfaq Ahmed. 2013. National Program for family planning and primary health care Pakistan: A SWOT Analysis. *Reproductive Health* 10(1): 60. doi:10.1186/1742-4755-10-60.
- Woratanarat, Thira and Patarawan Woratanarat. 2012. Assessment of prospective physician characteristics by SWOT analysis. *Malaysian Journal of Medical Sciences* 19(1): 60–64.
- World Health Organization. 2007. *Everybody's business. Strengthening health systems to improve health outcomes*. WHO's Framework for action. Geneva: World Health Organization.
- World Health Organization. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva: WHO