If this is well managed, quality will be improved and service users will benefit from a choice of high-quality sexual healthcare providers. This approach should also be more cost-effective.

Critics of this document will be frustrated by the recommendations that level 3 services provide clinical leadership and management across networks of care. Recent work from Bailey *et al*[7] has shown the ability of primary care to match case management standards but with no demonstrable public health or outcome measures. It is, therefore, imperative that level 3 providers recognise their responsibility to implement and facilitate improvement and attainment of all the standards.

The end goal is measurable improvements in the detection and treatment of STIs, to which all clinicians and commissioners aspire. The standards provide a quality benchmark This opportunity must not be lost. These are our standards. What will you do differently today to begin the process of implementation?

Competing interests None.

Provenance and peer review Commissioned; not externally peer reviewed.

Accepted 15 February 2010

Sex Transm Infect 2010;**86**:81–82.
doi:10.1136/sti.2010.042556

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The need for HIV prevention interventions for men who have sex with men in Africa

EDITOR'S CHOICE

James A McIntyre

Men who have sex with men (MSM) in Africa, largely ignored in HIV prevention and treatment efforts until recently, are the focus of a new wave of research and advocacy. Henry *et al*[1] in this journal edition (***see page 136***), provide the first report of MSM and HIV transmission risk in Cameroon. This work adds to recently published reports from a number of African settings, which together show a consistent pattern, and confirm that the transmission of HIV in African MSM is a significant problem.

The overwhelming scale of the heterosexual HIV epidemic in Africa, coupled with the political, social and cultural barriers against homosexuality, have meant that an MSM-focused response to HIV has been absent across the continent. New reports have shown prevalence rates in MSM higher than those in the general adult male population, with rates above 30% reported in a number of studies, including work from Zambia, Kenya and South Africa.[2–4] Most of these data have come from snowball referrals, respondent-driven sampling or venue-based recruitment, as a result of the challenges of reaching the hidden broader and diverse population of MSM.

It is not surprising that population-level data on MSM are so rare—same-sex relations are criminalised in 37 out of 54 African countries and are punishable by death in four of these.[5] Worldwide condemnation of recently proposed Ugandan legislation, which would mandate life imprisonment for homosexual acts and the death penalty for 'serial offenders' or HIV-positive MSM, has not yet halted the parliamentary progress of the law.[6] Against this background of discrimination, few African countries have made any provision for MSM-targeted HIV prevention or treatment plans. Indeed, only a third of African countries were able to report any information on MSM for the 2008 report on progress towards the goals of the Declaration of Commitment of the 2001 UN General Assembly Session of HIV/AIDS (UNGASS).[2] Government services do not provide appropriate support in these circumstances, and civil society groups who try to do so can themselves face harassment or prosecution. At an individual level, health workers may be expected to be more concerned about the health needs of MSM, but this does not always hold true. Low rates of disclosure of sexual practices to health workers, driven by fear of stigmatisation and reports of discrimination are a common feature in a number of African studies.[7 8] When health workers do not consider the needs of MSM, or raise barriers to their care, HIV prevention and treatment access will be impossible to achieve.

Limited as the current data from Africa are, a pattern is emerging of HIV risk behaviours in MSM and possible targets for intervention. Knowledge of HIV transmission risk, and particularly the risk of transmission from unprotected anal intercourse (UAI), is lower than expected in MSM communities. HIV prevention messages aimed at heterosexual populations do not provide information on MSM risk, and very rarely address anal sex, even in a heterosexual context. In this environment, misconceptions about the potential risks of male-to-male transmission can easily be perpetuated. UAI is reported as a common practice in several African studies: 57% of participants in the Cameroon study reported UAI with male partners, as did 59% in a Soweto study.[1 3] In one study of MSM in Mombasa, Kenya, 35% did not know that HIV could be transmitted through anal sex, and this lack of knowledge was associated with an increase in the practice of UAI.[9]

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Other factors associated with UAI include self-identification as gay, having had an HIV test, lack of access to prevention interventions or being less likely to use latex-compatible lubrication, and not knowing any HIV-infected persons.[10–12]

Alcohol use is a common association with risk behaviour and HIV infection in African MSM.[13 11] Transactional sex has also been described as a common risk factor for HIV infection—exchanging money or gifts for sex with a casual partner—although the boundary between perceived casual transactional sex and commercial sex work may be hard to define. One study in Mombasa, Kenya, estimated that there were over 700 MSM willing to sell sex in the city, and the researchers contacted over 400 of these in one night.[14] A similar capture–recapture enumeration methodology used in central Johannesburg identified over 400 MSM sex workers in 2 nights.[15] These studies suggest an urgent need to tailor prevention campaigns to MSM sex workers and their clients.

Another finding across a number of studies is a high level of bisexual concurrency, with MSM often reporting having both male and female partners.[7 3] More attention may need to be paid to circumcision as a prevention strategy for MSM in these settings in which concurrent female partners are common. Although the promotion of male circumcision has not been supported for MSM in general, circumcision was associated with a lower rate of HIV infection in one South African MSM study.[3]

Even access to standard prevention commodities of condoms and water-based lubricants remains a major challenge for MSM in Africa. Although effective condom distribution networks have been strengthened in many African countries, and state-funded services may provide free condoms, the provision of water-based lubricants is completely neglected. When such lubricants are not available, MSM are using petroleum jelly, body creams and other non-latex-compatible products, and may not be aware of the risk of doing so.[7]

The Cameroon data highlight one intervention that can be expanded to serve African MSM—the use of peer-implemented and adapted prevention messaging can be an effective way to reach MSM communities with accurate information and to distribute prevention materials. Policy makers, planners and funding agencies should support such interventions, as they should also reinforce the responsibility of health workers and health services to provide appropriate care for MSM. The international recognition of the need to address HIV prevention and treatment for MSM in Africa is the first step towards an inclusive and non-discriminatory response, but much more must be done to understand the need and to intervene successfully.

Funding JAM is supported in part by the US National Institute of Allergy and Infectious Diseases (NIAID) through the Comprehensive International Program of Research on AIDS (CIPRA) network, grant U19 AI53217. The content of this publication does not necessarily reflect the view or policies of NIAID, nor does mention of trade names, commercial projects, or organisations imply endorsement by the US government.

Competing interests None.

Provenance and peer review Commissioned; not externally peer reviewed.

Accepted 6 January 2009

Sex Transm Infect 2010;**86**:82–83.
doi:10.1136/sti.2009.041640

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