Together Tomorrow
PARTNERSHIPS INFORMING THE FUTURE

A brief overview of findings: A focus on Namibia December 2017

Introduction

Together Tomorrow is a mixed methods study exploring the HIV prevention needs of male-male couples in South Africa and Namibia. This study, consisting of both qualitative and quantitative phases, involved 589 partnered gay, bisexual and other Men who have sex with men (MSM) (across phases and sites) to better understand the stressors faced by these couples, relational dynamics, HIV prevention and treatment needs, and potential areas of systems and programmatic strengthening. The results presented below, provide a brief overview of aggregated results, with specific emphasis on Namibia.

Research question

What is the role of relationship dynamics & minority stressors on HIV risk taking behaviors and HIV prevention uptake among MSM couples in Southern Africa?

Sample Size

	Namibia	South Africa
Key informant interviews (KIIs)	15 KIIs	20 KIIs
Focus Group Discussion (FGD)	5 FGDs 31 MSM	8 FGDs 64 MSM
Couple in-depth interview (CIDI)	11 CIDIs 22 MSM 140	16 CIDIs 32 MSM
Quantitative surveys	MSM/70 couples	300/150 couples

Location

Namibia
Windhoek
Keetmanshoop
Walvis Bay
Swakopmund

South Africa
Kwazulu Natal

Primary respondents

MSM couples:
- Over the age of 18.
- Identify as Male
- Be in an intimate relationship for longer than 1 month (Qualitative phase and 3 months (quantitative)

Average age: 27,4 (Average) 29 (NAM)

Secondary education 66% (Average); 75% (NAM)

Tertiary education 28% (Average); 18% (NAM)

Employed 30% (Average); 44% (NAM)

Identify as Gay 71% (Average); 65% (NAM)

Relationship <12 months **28% (Average); 28% (NAM)**

Sample: 220 quantitative surveys

Results

Health Service Engagement

Perceptions of Health care service.

Respondents largely viewed public health services as spaces catering primarily to heterosexuals, with limited access to tailored services for MSM). Respondents indicated that they often felt that this caused increased levels of homophobia and ridicule within these spaces, and elected to not disclose their sexual orientation. Many also preferred making use of health services offered by private institutions and civil society. The main factors leading to low service uptake were fear of knowing one's status, fear of losing one's relationship (if tested positive) and the reactions of insensitive/prejudiced health care workers.

Sample: Nam: FGDs (5), CIDIs (11); SA: FGDs (8), CIDIs (16)

Overview of survey responses on Health knowledge, attitudes and needs

*1st % refers to Average over both sites (Av), 2nd % specific to Namibia (NAM)

Reasons for not testing

I don't want to know	Afraid	Don't want to go to a public place	Don't want to go to a MSM place	Relationship isn't strong enough	Afraid partner would tell
23% (Av); 25% (NAM)	24% (Av); 18% (NAM)	5% (Av); 4% (NAM)	7% (Av); 7% (NAM)	13% (Av); 16% (NAM)	12% (Av); 14% (NAM)

Health Service Needs

Non-judgmental	MSM welcoming	Know hetero couples who have used the service	Know same sex couples who have used the service	Confidential	Free condoms/lube	opening time
56% (Av); 50% (NAM)	49% (Av) ; 52% (NAM)	20% (Av); 20% (NAM)	43% (Av); 47% (NAM)	30% (Av); 38%(NAM)	26% (Av); 29% (NAM)	23% (Av); 29% (NAM)

Willingness to adopt prevention behavior

Use condoms with primary partners	Use condoms with casual partners	Only have anal intercourse in a monogamous relationship	Wait to have sex until both tested	HIV test in a clinic	Self-test for HIV	Couples HIV Counseling and testing
10% (Av); 12% (NAM)	20% (Av); 21% (NAM)	7% (Av); 10% (NAM)	12% (Av); 15% (NAM)	91% (Av); 93% (NAM)	55% (Av); 45% (NAM)	34% (Av); 40% (NAM)

In general, HIV prevention and transmission knowledge levels were quite high, with the exception of PreP: only 33% of respondents had heard of PreP, and only 2% of respondents across study sites (0.8% NAM) are currently on PReP. Note, PREP has only recently been rolled out in Namibia.

Sample: 220 qquantitative surveys

Sexual Agreements

Common Type of agreements

Monogamous:
a) Implicit
b) Explicit
78 % (Av); 85% (Nam)

Explicit Open With female partner:
15 % (Av); 12 % Nam

While monogamous agreements were high, about 20% of respondents across study sites indicated that they had had sex with someone other than their primary partner in the last 3 months.

POWER and discrepant agreements

The "top" or more dominant partner tends to own the power to negotiate seeking outside partners in sexual agreements. In some cases, a partner described the terms of their sexual agreement differently to his partner.

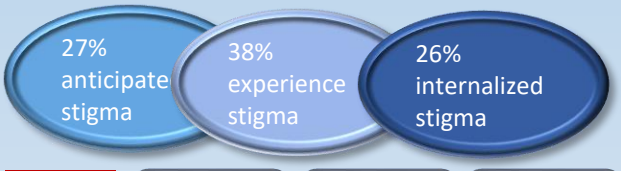
Clarifying Terms:

A top is usually a person who engages in the penetrative role during sexual activity, while the bottom partner is the receptive partner. **42%** indicated that they are predominantly top partners, while **35%** is predominantly bottom. **23%** of Namibian study respondents indicated that they are versatile, they enjoy both topping and bottoming.

Sample:: Nam: FGDs (5), CIDIs (11), 70 quantitative questionnaires; SA: FGDs (8), CIDIs (16); 150 quantitative questionnaires

Stress and Risk

17% of respondents (220 respondents) expressed variables indicating depressive symptoms, and named similar stressors, despite legal protection existing in South Africa.



Mechanisms used to reduce stress.

Denial
Participants often denied that sexual orientation related stigma and discrimination caused distress

Hiding
Many participants hide through acting straight or maintaining a concurrent heterosexual relationship

Substance abuse
Participants reported using alcohol or substances to lower inhibitions or reduce pain during anal intercourse

Sexual Risk Taking behaviors	Average across sites	Namibia
Drug use in past 3 months	46%	54%
Binge drinking past month	51%	59%
Sex while drunk in past month	59%	59%
Sex while high in past month	23%	22%
Did not use a condom at last sex with primary partner.	25%	28%
Had sex partner other than primary partner in past 3 months	20%	22%

Sample:: Nam: FGDs (5), CIDIs (11), 70 quantitative questionnaires; SA: FGDs (8), CIDIs (16); 150 quantitative questionnaires

Recommendations

1. **Rights-based health services:** Appropriate and comprehensive services call for tailored interventions to ensure the integration of and inclusion of issues of sexuality, sexual orientation, gender identity and gender expression and human rights.

2. **Institutionalizing SRHR:** There is an overwhelming need to strengthen the integration of comprehensive sexual and reproductive health rights (SRHR) in health interventions, starting from the training of health practitioners, to ensure institutionalization, standardization and sustainability of standard operating practice.

3. **Strengthening harm reduction, psychosocial and relationship support:** Strengthening linkages to psychosocial and harm reduction support is of the utmost importance to redress harmful defense mechanisms employed when facing stressors. Self-stigma also needs to be addressed within the relationship, and broadly within the gay, bisexual and MSM community to ensure that overall well-being is attained. Communication skills will also enable partners to develop concise sexual agreements.

4. **Strengthening the multi-sectoral response**
The need for SRHR integration extends health facilities, to ensure comprehensive health care for diverse populations. This should also be foundational to other public services, including law enforcement, social workers, educators among other.
Our national monitoring systems should be aligned across sectors, and should make provision to capture these various populations groups, such as gay, bi-sexual and MSM. Synergies should be sought across sectors, to allow for the co-implementation of interventions, to ensure cost and implementation efficacies. This also calls for all sectors to collaborate in processes of legal and policy reform to allow for legislation that enables equal access to SRHR services.

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