

Article

HIV Treatment Services Among Men Who Have Sex with Men During COVID-19 in Limpopo Province, South Africa

Betty Sebati ^{1,*}, Edith Phalane ¹, Amukelani Bilankulu ² and Refilwe Nancy Phaswana-Mafuya ¹

¹ South Africa Medical Research Council/University of Johannesburg Pan-African Centre for Epidemics Research Extramural Unit, Faculty of Health Sciences, Johannesburg 2092, South Africa; edithp@uj.ac.za (E.P.); refilwep@uj.ac.za (R.N.P.-M.)

² Anova Health Institute, Polokwane 0700, South Africa; bilankulu@anovahealth.co.za

* Correspondence: bettysebati800@gmail.com; Tel.: +27-115-591-496

Abstract

Men who have sex with men (MSM) are part of the key populations (KPs) that are susceptible to Human Immunodeficiency Virus (HIV) acquisition, transmission, and disruptions to access HIV services. This study aimed to explore and describe the HIV interventions implemented among MSM during the COVID-19 lockdown in the Capricorn District of Limpopo Province in South Africa. This study followed an exploratory qualitative study design with a purposive sample of 16 men who identified as MSM. Data were collected through in-depth interviews which were tape-recorded, transcribed verbatim, and captured on Atlas.ti. Patterns from the created codes were formulated into themes/sub-themes guided by the Consolidated Framework for Implementation Research (CFIR). The MSM had a mean age of 27.9 years. Various constructs and domains of the CFIR showed that during the COVID-19 lockdown, MSM encountered a disruption of HIV services. The response time was elongated, thus increasing the complexity of interventions. Interventions were implemented to ensure continuity of services. These included tailoring the programme through a door-to-door strategy and offering resources to healthcare facilities to enable MSM to access antiretroviral therapy (ART) and related services. The relative advantage of the programme is that it prioritises MSM. Future research should look into COVID-19's impact on a bigger scale.

Keywords: men who have sex with men; COVID-19; HIV treatment; consolidated framework for implementation research



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1. Introduction

The world experienced the COVID-19 pandemic in the years 2019–2020. Consequently, South Africa, among other countries, implemented lockdown measures to mitigate and curb the spread of the virus [1]. In South Africa, the COVID-19 lockdown was in effect from 26 March 2020. It was divided into five lockdown levels, with level five being the most restrictive and level one being the least restrictive. Lockdown level five started on 26 March 2020, and they transitioned all the way to level one, which was in effect from 1 October 2021 [2]. These included imposing several measures such as curfews, daily and continuous wearing of masks, the use of hand sanitisers, maintenance of physical distance, and bans on meetings and travelling. Only on 5 April 2022 was the national state of disaster lifted in South Africa [1,2]. Notwithstanding that these actions could have helped in controlling the spread of the virus, accessibility to the Human Immunodeficiency Virus (HIV)

services was substantially affected by COVID-19 both health-wise and socio-economically, particularly among people living with HIV (PLHIV) as well as key populations (KPs), i.e., men who have sex with men (MSM) [2]. This burden was compounded by the prevailing discrimination, stigma, and marginalisation already experienced by MSM [3].

Key populations are particularly susceptible to HIV acquisition, COVID-19, and interruptions in the delivery of HIV care [4]. Globally, MSM accounted for 23% of new HIV infections [5]. Furthermore, the MSM have a 25-fold greater probability of contracting HIV than other adult men who do not identify as MSM in terms of their sexual orientation [4]. There are several categories of sexual orientations among MSM, including gay and bisexual [6]. To maintain an undetectable viral load and help contain the HIV epidemic, the KPs need to have access to HIV services such as HIV testing, as well as antiretroviral therapy (ART) initiation, retention, and adherence [7].

Fear, isolation, anxiety, and even stigma have all increased as a result of the COVID-19 pandemic. This might negatively impact the health outcomes of MSM who are on ART, in addition to possible connections between HIV and COVID-19 [8]. Therefore, it is crucial to establish how these connections could impact their well-being, particularly those living with HIV, to emphasise the need for pertinent and tailored HIV care services. To understand the challenges faced by MSM during the COVID-19 lockdown, personal experiences and invaluable insights will be explored. This will be achieved through the application of the Consolidated Framework for Implementation Research (CFIR), which is a research tool widely utilised to predict, identify, or elucidate obstacles and enablers to the efficiency of implementations, also referred to as a determinant framework [9]. The five domains that constitute the CFIR include the inner setting, individual characteristics, intervention characteristics, outer setting, and process [10].

By identifying the challenges faced by MSM to access and adhere to HIV treatment during the COVID-19 pandemic using the CFIR, this study explored strategies to mitigate the identified barriers and advise policymakers and other relevant stakeholders on the measures identified by this study to sustain HIV treatment for this population. Consequently, HIV outcomes for MSM might improve while ensuring preparedness for future pandemics. Therefore, this study aims to explore and describe the HIV interventions implemented among MSM during the COVID-19 lockdown in the Capricorn District.

2. Materials and Methods

2.1. Study Design

An exploratory qualitative study design was followed. The design enables the exploration of people's experiences and seeks to comprehend a phenomenon or concept in greater detail as well as discover new information. Therefore, it enables study participants to add to new knowledge in that particular field [11].

2.2. Study Area

This study was conducted in Limpopo Province's Capricorn District, South Africa. The study setting is among the five district municipalities in the province. The province's capital, i.e., Polokwane, which is the province's economic hub, is under the jurisdiction of the Capricorn District Municipality [12]. Our local municipalities that constitute the district municipality are Blouberg, Molemole, Polokwane, and Lepelle-Nkumpi [12]. With 113 wards and 28 traditional authorities, the district's 185,222.27 hectares make up 12% of the province's total surface area. With a total population of 1,372,355 million, Capricorn District municipality accounts for 2.3% of South Africa's population, and almost 23% of the province's population [12].

2.3. Men Who Have Sex with Men in Limpopo Province

Limpopo Province is approximately 90% rural [12], with an estimated HIV prevalence of 35.7% among MSM in 2024 [13]. Similarly to MSM in other settings, the MSM in Limpopo Province experience stigma and discrimination, also due to cultural norms [14]. They have limited access to MSM-friendly and specific MSM care, particularly in the rural areas [15]. The MSM's access to HIV care services in primary health facilities is limited by the insensitisation of public health workers towards MSM's sexualities, the generalised approach to the provision of HIV-related services which do not cater to their specific needs, and a lack of resources in some facilities [16,17]. Hence, there was an implementation of the MSM programme to cater to their unique needs and reduce HIV transmission. The MSM programme was implemented in the Capricorn District, serving approximately 6000 MSM. There are other similar programmes in other districts within the Limpopo Province; however, the MSM programme in the Capricorn District is the largest one [18].

2.4. Sampling

A purposive sample of the study consisted of 16 MSM, which was determined by data saturation. The minimum sample size required to reach data saturation for qualitative research was reported to be 12 people [19]. However, even when the sample size is compliant, it remains the researcher's responsibility to ensure that the appropriate sample size is included for adequate response to the study aim.

The recruitment of the interviewees was conducted, assisted by an MSM community gatekeeper who is part of a non-profit organisation (NPO). The NGO in question implemented the largest MSM programme in the Capricorn District Municipalities. They offered HIV services to MSM in the district and supported the South African National Department of Health (NDoH) regarding access to and delivery of HIV services. The MSM community gatekeeper introduced the researcher to the participants and interested MSM were invited to participate in the study.

The criteria for inclusion were men who identified as MSM, were clients of the MSM programme in the Capricorn District municipality during the COVID-19 lockdown, aged 18 years or older, and who gave written informed consent to participate.

2.5. Data Collection

In-depth interviews were carried out to collect data using open- and closed-ended questions from 26 February to 15 March 2024 for a duration of 20–35 min per interview. All 16 MSM were interviewed to completion. The interviews elicited information on the experiences of MSM regarding HIV services accessibility and utilisation amid the COVID-19 lockdown. The questions concentrated on the following: HIV care needs and preferences, challenges and barriers to timely HIV testing, linkage to care, ART refill, ART adherence, viral load tests, attendance of clinic visits, the ability of the programme to adapt to the changes brought by COVID-19 and ensure continuity of services, communication platforms, and recommendations to improve the programme in settings comparable to the COVID-19 lockdown based on their experiences. Open-ended questions were utilised to probe into the detailed experiences of MSM (Appendix A). Verbatim recordings of the interviews were taken and supported by a tape recording for accuracy purposes. Furthermore, field notes were made to supplement the recorded information. No personal or identifiable information about the MSM was disclosed by the organisation whatsoever during this process. It is only the organisation's management that can access the personal information of the MSM. Furthermore, the MSM who expressed interest gave consent to participate in the interviews. The interviews were held one-on-one in a secluded room at the organisation's offices where services were rendered.

The CFIR was applied to evaluate the implementation of the MSM programme, and the access and utilisation of HIV treatment services by the programme recipients (i.e., MSM) during the COVID-19 lockdown period, based on the relevant CFIR domains and constructs [9]. The CFIR provides a complete theory-based system which works well for qualitative implementation research. The framework structures influential factors into five domains (as shown in Table 1 below) to provide a systematic approach for qualitative data interpretation. The framework's adaptability enables researchers to customise it to specific contexts, while maintaining research rigor and improving comparability across studies [9]. Table 1 below shows the domains and constructs that the current study focused on [9].

Table 1. Constructs and domains analysed in this study.

Domains	Constructs
Intervention	Adaptability Complexity Relative advantage
Outer setting	Critical incidents Partnerships and connections Policies and laws/regulations
Inner setting	Structural characteristics: Physical and work infrastructure Communications Relational connections
Individual characteristics	Innovation recipients: Need, opportunity, motivation
Implementation process	Engaging: Innovation recipients Tailoring strategies Assessing needs: Innovation recipients

2.6. Data Analysis

Atlas.ti was employed to capture qualitative data [20,21]. A ground-up approach wherein codes result from the research data, referred to as inductive coding, was used [22]. A thorough review of the entire data was conducted to acquaint the researcher with its content. Before analysing the data, the interviews were transcribed verbatim; thereafter, the entire dataset was read to generate codes in alignment with the CFIR constructs. Patterns from the created codes were used to formulate themes and sub-themes where applicable. To analyse open-ended questions, thematic content analysis was used, while close-ended questions were analysed descriptively.

NB: All participants' responses were included in the thematic analysis, although not all quotes were included in the manuscript. The included quotes were selected based on the best representation of the themes and constructs, while representing a range of MSM perspectives.

2.7. Ethical Considerations

This study has undergone review and approval by the University of Johannesburg's Research Ethics Committee (REC) (REC-1949-2023) and the MSM community gatekeeper in the Capricorn District, Limpopo Province. All participants were requested to provide written consent to participate in the interviews. All the transcriptions and recordings were secured and coded in protected files with controlled access, while hard copies were locked in cabinets in offices with controlled access. Hesitancy to participate in the study did not affect the programme services received by the participants.

3. Results

Table 2 below shows the general characteristics of the interviewed MSM. Of the 16 MSM interviewed, 13 identified as gay, while three identified as bisexual. The MSM's ages ranged from 20 to 38 years, with a mean age of 27.9 years. Four of the MSM stayed in semi-urban locations, five in rural locations, six in urban locations, and one in a semi-rural location. Overall, nine of the MSM completed tertiary education, while seven only completed up to Grade 12 (matric) level. Only six of the MSM were employed during the COVID-19 lockdown, including one who was self-employed, while eight were still studying (five at the high school level, and three at the tertiary level), one was in a learnership programme, and one was unemployed. Lastly, all the MSM were black and unmarried or single.

Table 2. General characteristics of the study participants.

Participants	Sexual Orientation	Age (Years)	Race	Highest Education Level Completed	Type of Location	Marital Status	Employment Status During the COVID-19 Lockdown
MSM 1	Gay	27	Black	Grade 12	Semi-urban	Single	Studying (High school)
MSM 2	Bisexual	28	Black	Diploma	Semi-urban	Single	Employed
MSM 3	Gay	30	Black	Honours	Rural	Single	Employed
MSM 4	Gay	34	Black	Diploma	Urban	Single	Self-employed
MSM 5	Bisexual	23	Black	Grade 12	Rural	Single	Studying (High school)
MSM 6	Gay	29	Black	Diploma	Urban	Single	Learnership
MSM 7	Gay	29	Black	Grade 12	Rural	Single	Unemployed
MSM 8	Gay	24	Black	Higher certificate	Semi-urban	Single	Studying (Tertiary)
MSM 9	Gay	38	Black	Higher certificate	Rural	Single	Employed
MSM 10	Bisexual	26	Black	Grade 12	Urban	Single	Studying (High school)
MSM 11	Gay	37	Black	Grade 12	Rural	Single	Employed
MSM 12	Gay	20	Black	Grade 12	Urban	Single	Studying (High school)
MSM 13	Gay	27	Black	Diploma	Semi-urban	Single	Studying (Tertiary)
MSM 14	Gay	31	Black	Degree	Urban	Single	Employed
MSM 15	Gay	22	Black	Degree	Semi-rural	Single	Studying (Tertiary)
MSM 16	Gay	22	Black	Grade 12	Urban	Single	Studying (High school)

3.1. Innovation

Table 3 below shows an assessment of the MSM programme's innovation during the COVID-19 lockdown.

Table 3. An assessment of the programme's innovation amid the COVID-19 lockdown.

Innovation Constructs	Description	Quotations
Adaptability	Visits to hotspots were prohibited during the initial stages of the COVID-19 lockdown. The ability of the programme to reach new clients was limited. With the existing MSM clients, the programme was able to reach and offer some of the clients' various services (HIV testing, transport to public facilities to collect ART, condoms, and lubricants, etc.) at their doorstep. While not all MSM were reached, the programme devised means to adapt its daily activities to ensure continuity of services during the COVID-19 lockdown period.	"We were able to get the services outside because they used to do outreach even during COVID-19, they used to do door-to-door. If I'm not at work, they will be going door to door coming straight to the door. If you want to do an HIV test, or you want this or that they are going to do it on your door." (MSM 3, 30 years old)

Table 3. *Cont.*

Innovation Constructs	Description	Quotations
Complexity	The COVID-19 pandemic has significantly complicated the MSM programme. It took longer than usual to receive assistance as one of the MSM shared below. This was worsened by the fact that some of the MSM lacked the contact details of the staff members, which made the accessibility of HIV treatment services complex. In certain instances, the MSM had to take the initiative to reach out to the programme implementors for assistance.	“The challenges is that they were taking time, as I’m saying, we had to contact one of the staff. If you don’t have the phone numbers, then you are unable to get help.” (MSM 1, 27 years old)
Relative advantage	Six of the MSM compared the HIV services offered in the MSM programme to those provided at public clinics and expressed the services in the MSM programme to be more beneficial, accommodating, and friendly. They appreciated that HIV services are the main priority of the MSM programme daily, while the public facilities offer various health services and are accessible to everyone. Furthermore, the health workers in public facilities were found to be less sensitive and more judgemental to the sexual preferences and activities of the MSM. One of the MSM suggested more facilities similar to those of the MSM programme.	“I think they have to build more facilities like this one because they are the ones working with those things of HIV to test people and provide them with PrEPs and give them the knowledge, you get my point. So, if they can build more facilities then they go to houses once a month to check clients and give them more information about HIV. Remember during lockdown, nurses are scarce. But those ones of ****, they can go because it’s their everyday duties.” (MSM 1, 27 years old)

3.2. Outer Setting

Table 4 below shows an assessment of the MSM programme’s outer setting during the COVID-19 lockdown.

Table 4. An assessment of the programme’s outer setting amid the COVID-19 lockdown.

Outer Setting Constructs	Description	Quotations
Critical Incidents	The greatest unanticipated event that disrupted the implementation and receipt of the programme is the COVID-19 pandemic and the resultant lockdown measures. The MSM programme implementors and recipients (along with the rest of the world) were unprepared to curb the COVID-19 spread and prevent the disruption of services. Hence, no prior arrangements were made to mitigate the impacts of COVID-19 on HIV treatment services. Due to the movement restrictions put in place by the government, the MSM could no longer visit the MSM programme offices or outreach hotspots at any time of their choice, while the MSM programme implementors were initially not operating. This led to one of the MSM below missing their HIV treatments for the first few months of the COVID-19 lockdown.	“During the early months of 2020 when COVID-19 started, that’s when we were really struggling and then after 2–3 months I went back to treatment. I went to the public facility first, then they said they could not help me because I did not have the transfer letter. So, it was hard for me to get to Polokwane because they needed a permission letter to travel to show that I was going to work. I did not have it, so I had to wait. Then I spoke to one of the home-based carers and that’s when I was able to get help. It was difficult. Let’s say for instance, if I have to go and collect medication on a certain day, I won’t go because I am afraid of soldiers and people on the road because they will ask me where I am going, I can’t say I am HIV positive and I am going to collect my medication because some things are private. I can’t just say I am positive; I am scared of people knowing my business and talking behind my back.” (MSM 8, 24 years old)

Table 4. *Cont.*

Outer Setting Constructs	Description	Quotations
Partnerships and connections	The MSM programme does not initiate people or ART themselves, they link their MSM clients who tested positive for HIV to the nearest facility of the client's choice. Their work is meant to assist the NDoH with reaching as many people as possible and they are successfully doing that. They have created great relationships and collaborations with some public clinics in the Capricorn District. During the COVID-19 lockdown period, some of the MSM had to relocate far from the public clinics where they normally receive their ART and go to clinics near their new locations which the MSM programme did not have a close working relationship with. The referral letter received through the programme was valid for use in any public clinic in the country. The MSM who were able to obtain referral letters were able to receive assistance even though they initially experienced challenges.	"Yes, I did change the location. Then I took it down at **** clinic. It was a local public clinic. It was a process though because you have to explain why you moved that side. My referral was written that at least I can get four to five months medication, but still even when it's written like that, it was a process for me to get 5-month medication. They were saying no, no government doesn't have medication. Why have they written five months? How so? It was a process. It was a process, I had to at least beg them to say guys, my situation is like this. Then that's when they try to understand. But it was tough but at the end they gave me but you could see that they are not happy with that five months." (MSM 11, 37 years old)
Policies and laws/regulations	The COVID-19 lockdown regulations did not initially support the implementation of the programme. It was not regarded as an essential service and had to close for the first few months of the COVID-19 lockdown, leaving no room for MSM to access the services needed from the programme or for the programme implementors to mitigate the COVID-19 implications. This led to the MSM feeling helpless without the programme, as one shared.	"The government should give access to them. Like even though it's COVID-19 but they must always be open. They must not close at all, at least because we need such health facilities like **** because without it we are still going to struggle, especially us the LGBTQ. Yeah, we're still going to suffer." (MSM 11, 37 years old)

3.3. Inner Setting

Table 5 below shows an assessment of the inner setting of the MSM programme during the COVID-19 lockdown.

Table 5. An assessment of the programme's inner setting amid the COVID-19 lockdown.

Inner Setting Constructs	Description	Quotations
Structural characteristics: Physical and work infrastructure	The MSM programme is a peer-led programme and conducts outreach activities daily to reach MSM in the identified hot spots. To achieve this, they currently use Gazebos and cars to travel to the hotspots and set up the Gazebos. Although they have been able to reach many MSM using this approach, one of the MSM expressed the need for the programme to use mobile clinic vehicles instead of Gazebos, and for the programme to employ more staff. More staff can potentially lead to outreaches taking place in multiple locations at once, while utilising mobile vehicles can provide the programme with a safe place to keep their materials, medications, etc., and ensure privacy for the MSM being assisted. Another of the MSM expressed their desire for the MSM programme facilities to be scaled up due to their dedicated focus on providing HIV services to MSM.	"I think if they take measures such as having a mobile clinic, they currently use Gazebos, and maybe hire more staff." (MSM 16, 22 years old) "I think they have to build more facilities like this one, because they are the ones working with those things of HIV to test people and provide them with ARVs, PrEPs and give them the knowledge, you get my point." (MSM 1, 27 years old)

Table 5. *Cont.*

Inner Setting Constructs	Description	Quotations
Communications	The MSM programme engages in both formal and informal communications on a wide variety of communication channels with MSM. All the MSM mentioned that they can communicate with the programme staff through WhatsApp, Facebook, MSM-specific dating websites (i.e., Badoo), phone calls, or face-to-face, and by handing out information, education, and communication (IEC) materials during outreach. Communications take place during MSM events organized by the programme implementors or one of their collaborators where the MSM get to reflect on the programme services, share their thoughts, or receive education on several aspects of the programme or MSM lifestyle. Some of these communication channels could not take place during this period. For instance, outreach and events were not allowed due to the prohibition of gatherings.	“If I needed something and was unable to reach the person on a phone call then I would send a WhatsApp. They would make a plan for me to be okay.” (MSM 7, 29 years old) “Even with IEC (i.e., information, education and communication) materials, sometimes they call me and say they are looking for a person of a certain age, living with HIV, who will be a motivational speaker at the communities at their event. They can go to different locations with the person. Sometimes they are looking for MSM, a gay person, sometimes a bisexual person.” (MSM 9, 38 years old)
Relational connections	Since its inception in 2019, the MSM programme has created and sustained formal and informal relationships with different parties across the district including the Department of Health, the Department of Social Development, other KPs organizations, and traditional councils in various villages. This has facilitated the successful functioning of the programme in most parts of the district. The collaboration with the Department of Social Development allows the MSM programme to refer economically challenged MSM to receive assistance with grants, food parcels, etc. The traditional council collaboration enables the MSM programme to conduct outreach in different places or introduce the programme to and host educational HIV gatherings for MSM in the communities, while partnering with other KPs organizations in the district allows support and more awareness of KPs. Moreover, they are able to refer MSM who are sex workers to join the sex workers programme in the district so they can benefit more. Not all MSM were able to benefit from this collaboration during the COVID-19 lockdown period; however, the collaboration with the Department of Health has resulted in less waiting time for the MSM to receive assistance in nearby public facilities, encouraging adherence of the MSM to ART, and making it easy for the MSM to reach out when they are in need of medical attention.	“They’re working hand in hand with the doctors at the local clinics. And other organizations. Let’s say if I have a problem and I come here at ***, it’s simple for me to go to bed without being in the queues and everything and make sure when I get there, they give a service. I won’t even stand in the queue. I just go with them, then they tell me which room to go to. Then they attend me and I get my medication or whatever I need. Because when I get here, I explain that guys, I am on my lunch break and I am supposed to go and get my medication. Then they take their van, along with us to the local clinic. *** is making things very very simple for us to be honest.” (MSM 11, 37 years old)

3.4. Individual Characteristics

Table 6 below shows an assessment of the characteristics of the MSM programme recipients amid the COVID-19 lockdown.

Table 6. An assessment of the characteristics of the programme recipients amid the COVID-19 lockdown.

Individual Characteristics Constructs	Description	Quotations
Need	All the MSM that participated in the current study expressed a need for the continuity of the MSM programme, and the positive impact that the programme had on their health and overall life. One of the MSM shared the following quote.	“The MSM programme has improved some of the quality services that you get in public facilities. So, their programme is doing fine, they are supporting us. Some of us are okay because of them.” (MSM 8, 24 years old)
Opportunity	Despite being the recipients or beneficiaries of the MSM programme, the MSM play a vital role in keeping the programme active and relevant by availing themselves to assist through offering their time and personal skills that may be beneficial to the programme and other recipients. For instance, one of the MSM mentioned that they get approached by the programme implementors to contribute when they have events. Thus, they are critical to the programme’s success and growth.	“Sometimes they are doing modelling and I say I can help with training for LGBTI people.” (MSM 9, 38 years old)
Motivation	The MSM that took part in the interviews were affected differently in terms of accessing HIV testing services from the MSM programme. All the MSM were finding it hard to adjust and were unable to freely reach out to the MSM programme outreach workers who are usually always accessible in various hotspots in town and their communities. Only two of the 16 participants stated that they were able to obtain HIV testing services through door-to-door services implemented by the MSM programme. Nonetheless, 14 of the MSM were unable to benefit from this effort, especially during the first three to six months of lockdown; due to restrictions, relocations to areas outside the district where the programme operates and staying in remote areas where the programme could not easily gain access were challenges in this period. Participants were eventually able to access the services once the lockdown restrictions were lowered and the programme could conduct outreaches again. Despite the fact that the COVID-19 outbreak has severely disrupted HIV services, all of the MSM in this study were highly satisfied, appreciative, and grateful for the programme’s execution, and they wished for it to continue indefinitely.	“Their services are good, and I hope they keep it that way. And I am satisfied.” (MSM 16, 22 years old)

3.5. Implementation Process

Table 7 below shows an assessment of the MSM programme implementation process during the COVID-19 lockdown.

Table 7. An assessment of the programme's implementation process amid the COVID-19 lockdown.

Implementation Process Constructs	Description	Quotations
Engaging: Innovation recipients	In addition to the MSM participating in the programme during events, they engage with the programme by referring and encouraging other MSM to partake in the programme. The programme implementors, particularly the outreach team, have made it comfortable for the MSM to engage in this manner. They have created a functional and trusting relationship which greatly encourages the MSM to engage in this manner.	"Sometimes there was a communication line in a specific point like if you know anyone who needs something, I would tell them. We talk and say let's do this and that, if I can get assistance, I can be able to help assist another one." (MSM 2, 28 years old) "I think the meetings that we have are very much educational at this point where they could do it more, have like interviews like this. Get to sit down with some people and get different perspectives on what people think with regards to the MSM programme. So as for now, I feel like they're doing a good thing because we have outreach. We have maintenance. They go to villages where they provide services like this." (MSM 15, 22 years old)
Tailoring strategies	Once they were able to operate a few months after the COVID-19 lockdown measures were put in place, the programme implementors tailored some of their daily services to fit the COVID-19 context, while ensuring that they could reach and offer their services to as many MSM as they could. They could no longer conduct outreach, and they resorted to communicating and visiting MSM on their doorsteps to offer their services. In some instances, they would transport the MSM to a public facility when their ART collection was due, then take them back to their doorstep. At a later stage, they were able to open their offices and invite the MSM to come for a few selected hours. Two of the MSM who benefited from the tailored strategies share their experiences below.	"I think at the stage where we were able to travel around because I remember at some point we were told to come and get what we need before 9 am or so, I don't recall well." (MSM 16, 22 years old) "We were able to get the services outside because they used to do outreach even during COVID-19, they used to do door-to-door." (MSM 3, 30 years old)
Assessing needs: Innovation recipients	Besides the HIV service-related needs, the MSM have many challenges that they need assistance with. This could be related to identifying and understanding their sexual orientation and the MSM lifestyle, health education, or even getting their families to accept them as one of the MSM mentioned below. The programme goes the extra mile in identifying the sexual, health education, psychological, or even personal needs of the MSM. The MSM programme has a comprehensive team of professionals including professional nurses and psychologists to effectively respond to the various needs of the MSM.	"Basically, the programme helped me a lot because they gave me any information starting from health education. About health education, they would tell me about HIV testing, TB screening, STIs. Secondly, when it comes to psychologically, as an MSM myself, I was not aware that my sexual orientation is like this. I was just thinking that maybe I just love having sex with another man. They made me to be aware that there are people who have sex with sex. And to give me the courage that if my family does not understand, they will assist to make them understand my sexual orientation." (MSM 3, 30 years old)

Table 8 below summarises the findings of this study by CFIR domains and the associated quotes.

Table 8. Summary of main findings by the consolidated framework for implementation research domains and selected quotes.

CFIR Domains	Description	Quote
Intervention	The MSM programme is preferred by MSM for its primary focus on providing HIV services to MSM and for following a client-centred approach. Hence, the MSM require an expansion of similar services. During the COVID-19 lockdown, the programme showed great adaptability by moving from hotspot outreach to door-to-door service delivery. The programme was able to maintain continued service delivery to MSM despite challenges, such as elongated response times.	“We were able to get the services outside because they used to do outreach even during COVID-19, they used to do door-to-door. If I’m not at work, they will be going door to door coming straight to the door. If you want to do an HIV test, or you want this or that they are going to do it on your door.” (MSM 3, 30 years old)
Outer Setting	The external environment played a major role in affecting the delivery and accessibility of MSM HIV services during the COVID-19 pandemic. The pandemic itself proved to be the most disruptive factor since it led to immediate lockdowns and travel limitations. This limited both the MSM and the programme implementors, therefore disrupting service continuity and resulting in some clients missing their treatment. The government policies and lockdown regulations first barred the MSM programme from providing essential services, which forced it to close down temporarily. The service gap exposed MSM to risk, while demonstrating why community-based HIV services need to be included in emergency response plans.	“The government should give access to them. Like even though it’s COVID-19 but they must always be open. They must not close at all, at least because we need such health facilities like **** because without it we are still going to struggle, especially us the LGBTQ. Yeah, we’re still going to suffer.” (MSM 11, 37 years old)
Inner Setting	The MSM programme demonstrated flexibility through its use of vehicles to maintain service continuity during the COVID-19 lockdown. The participants suggested that mobile clinics, as well as additional staff, would further improve the services. The programme maintained communication with MSM through WhatsApp and Facebook in addition to phone calls. This allowed MSM to stay connected to the programme implementors during times when in-person interactions were not possible. The programme’s strong connections with local clinics and community partners enabled most MSM to obtain care in a timely manner, although not all MSM benefited from the programme during this challenging period.	“They’re working hand in hand with the doctors at the local clinics. And other organisations. Let’s say if I have a problem and I come here at ****, it’s simple for me to go to bed without being in the queues and everything and make sure when I get there, they give a service. I won’t even stand in the queue. I just go with them, then they tell me which room to go to. Then they attend me and I get my medication or whatever I need. Because when I get here, I explain that guys, I am on my lunch break and I am supposed to go and get my medication. Then they take their van, along with us to the local clinic. **** is making things very very simple for us to be honest.” (MSM 11, 37 years old)

Table 8. *Cont.*

CFIR Domains	Description	Quote
Individual Characteristics	The COVID-19 lockdown revealed that MSM wanted the programme to continue because it benefited their health and well-being. The programme maintained its positive impact on MSM, who continued to show appreciation for its services. Most of the MSM faced restricted access to HIV services during the initial lockdown period, while some received some services (i.e., HIV testing, and provision of condoms and lubricants) through a door-to-door approach. Prior to the lockdown and afterwards, as the lockdown levels eased, MSM actively participated by offering their skills during programme events, which demonstrated their dual role as both recipients and essential partners in the programme's achievements.	"The MSM programme has improved some of the quality services that you get in public facilities. So, their programme is doing fine, they are supporting us. Some of us are okay because of them." (MSM 8, 24 years old)
Implementation Process	The programme implementors expanded their services to include health education, psychological support, and sexual identity acceptance and disclosures in addition to HIV services. The flexible, holistic approach enabled many MSM to feel seen, supported, and empowered during an uncertain and isolating period. The programme was able to tailor its services following the COVID-19 restrictions to ensure continued service provision to the MSM. Further, the existing MSM clients took part in the programme by encouraging and recruiting other MSM to join.	"Basically, the programme helped me a lot because they gave me any information starting from health education. About health education, they would tell me about HIV testing, TB screening, STIs. Secondly, when it comes to psychologically, as an MSM myself, I was not aware that my sexual orientation is like this. I was just thinking that maybe I just love having sex with another man. They made me to be aware that there are people who have sex with sex. And to give me the courage that if my family does not understand, they will assist to make them understand my sexual orientation." (MSM 3, 30 years old)

4. Discussion

The current study found that the COVID-19 lockdown and associated measures implemented to manage the virus have significantly disrupted the MSM programme in the Capricorn District Municipality, South Africa. Visits to MSM hotspots were prohibited at the beginning of the COVID-19 lockdown. The capability of the programme to reach new clients was limited. During the COVID-19 lockdown onset, the MSM programme had to temporarily close as it was not considered an essential service, although the programme was later resumed due to the provision of travelling permits issued to the MSM programme implementors by the Limpopo Department of Health. This was fostered by the partnership and connection that the programme had built with the department, as reflected in the outer setting domain. The programme has created and sustained formal and informal relationships with different parties across the district, including the Limpopo Department of Social Development, other KPs organisations, and traditional councils in several villages. Additionally, MSM are also essential to maintaining the programme's viability since they volunteer their time and personal abilities to the programme and other recipients. The programme implementors adapted and tailored aspects of their everyday services to meet the COVID-19 conditions when they were able to operate a few months after the COVID-19 lockdown measures were implemented, thus ensuring the continuity of HIV services to as many MSM as possible.

For the continuation of HIV services provision to MSM, the programme was adapted and tailored accordingly through implementations like the door-to-door strategy to safely provide HIV tests and distribute condoms and lubricants among other services to MSM, at their doorsteps. Additionally, transporting MSM to the designated or nearest public health facility to access their ART further demonstrated the adaptability of the programme. These findings are supported by a qualitative study conducted among programme implementers of the same MSM programme explored in the current study [18]. One of the major factors that enabled the programme to effectively tailor their services and reach more MSM was the interdisciplinary teamwork of the programme implementers. The roles included a programme liaison officer, team leaders, an outreach team, HIV testing services, and retention counsellors, social workers, and nurses [18]. Nonetheless, due to the COVID-19 lockdown, not all clients could be reached through this approach because some of them relocated to other districts and remote areas, with some of those areas being out of bounds for the programme to reach them. Consequently, some MSM were not able to adhere to ART due to challenges accessing it in their local public clinics. Furthermore, barriers included the movement restrictions imposed amid the lockdown, a lack of a transfer letters for the clients of the programme, uncooperative nurses in public health facilities, and the fear of COVID-19 contraction. Fortunately, none of the MSM in the current study were infected with COVID-19; however, some had loved ones who experienced COVID-19 infection during the lockdown. Contrary to the current study, another study conducted in Thailand reported that MSM had appropriate access to ART, thus they were able to sustain ART adherence [3]. Their desire to maintain their immune system in good health enabled them to adhere to ART. Furthermore, the MSM were able to continue receiving HIV care due to the implementation of several strategies for HIV service delivery, including the usage of booths that are accessible by car, fast-tracked ART pick-up services, and home ART delivery [3].

Similarly, another study reported COVID-19 lockdown movement restrictions, including police roadblocks, as the number one barrier to MSM accessing HIV services, with these leading to a fear of invasive questioning by the police [23]. Some MSM would sometimes postpone collection of their ART on a given date due to a fear of police and unplanned HIV status disclosures, as reported in the current study. These may have been evaded if the MSM received letters authorising them to visit HIV centres to receive their treatment and other services; however, securing the permission letters had proven to be difficult [24]. In Zimbabwe and Uganda, public transportation frequently faced delays and took a long time to arrive at treatment centres [23]. In South Africa, similar delays could have been barriers because public transport could only carry very few passengers at a time to maintain social distancing [25]. Possibly, all of the above could have been mitigated by implementing eHealth services to enable MSM to access the required HIV services in the comfort of their own homes, thus promoting ART adherence [2,26].

Moreover, some MSM have lost their jobs or sources of income due to retrenchment or the temporary closure of companies. This led some MSM to relocate from Polokwane city to their homes in villages and townships, where the MSM programme, in most instances, could not easily reach them. Similar findings were reported wherein several KPs lost their jobs, including at gay clubs and informal employment [27]. Some MSM who were forced to return home due to job losses faced homophobic hostility from their families [27,28]. In addition, the COVID-19 lockdown reduced opportunities for MSM to contribute and participate maximally in the programme. For instance, the events that the programme used to host for MSM to share their needs and thoughts on the programme were halted due to restrictions on gatherings. However, the need and motivations of the programme remained

significant. The importance of ensuring that programme implementation is centred around the recipients' needs, and feedback for its success were emphasised [29].

In terms of policies and legislation, same-sex relationships are allowed in South Africa [30]. In 2006, same-sex couples were permitted to engage in civil marriages with the same obligations and outcomes as heterosexual couples entering a marriage. Even though MSM are legally protected, some communities in South Africa still do not accept homosexual relationships [31,32]. Consequently, MSM still experiences stigma, discrimination, and hate crimes, including murder [33].

Despite all the barriers that MSM experienced with access, utilisation, and contribution to the MSM programme services in this study, they were content with the programme implementation in the Capricorn District because it is the first programme of its magnitude in the province. It is a peer-led programme that aims to reduce STIs, particularly HIV, among MSM in a sensitised setting that protects their privacy and confidentiality [34]. It was reported that the MSM in Zimbabwe had received peer support through arranged calls or virtual channels like WhatsApp [23]. Similarly, the peer outreach team in the current study were in constant contact with the MSM to support them during the COVID-19 lockdown, including those who could not be reached physically.

The interventions implemented to mitigate the impact of COVID-19 to ensure continuity of HIV treatment services in the current study are related to the differentiated service delivery (DSD) models that have been proven to be effective in several HIV-burdened, high-stigma, and low-resourced parts of Africa [23,35–37]. Hence, these interventions are potentially transferable to similar rural or semi-urban environments where MSM or other KPs face similar structural barriers such as stigma, discrimination, or even poor infrastructure and movement-restricted conditions similar to the COVID-19 lockdown or similar future pandemics. Furthermore, the contextual tailoring of these interventions can greatly support their implementation [38], including engaging local MSM peer educators and leveraging existing community health support structures [37,39]. These may further be adaptable in low- and middle-income countries with marginalised populations experiencing similar health system challenges within and beyond Africa [40].

Strengths and Limitations

This study is focused on MSM, who are a part of the key and vulnerable populations in the world. The findings of this study will add to knowledge and inform policymakers on the barriers impeding access to ART among this population and guide the implementation of interventions, including supporting structures to increase the uptake of ART. This will meaningfully contribute towards meeting the 95-95-95 UNAIDS goals and get us closer to ending HIV as an epidemic by 2030.

The employment of the exploratory qualitative study design facilitated a deeper and more comprehensive analysis of MSM's experiences during the COVID-19 lockdown. Considering the self-reported structure of this study, the possibility of response bias cannot be excluded. Furthermore, since this study only focused on MSM getting HIV care services from one NGO in one district within Limpopo Province, the findings of this study cannot be generalised to those receiving similar services from different service providers, including governmental health facilities, nor can it be generalised to the entire province. Hence, the possibility of selection bias cannot be excluded from this study. Nonetheless, the information generated from this study can effectively be used to guide the improvement and tailoring of the HIV treatment services provided to MSM.

5. Conclusions

The relative advantage of the MSM programme is its prioritisation of MSM, a group having one of the greatest HIV prevalences and incidences globally. Despite the above, the MSM programme was disrupted by the COVID-19 lockdown restrictions. In spite of the adaptations and tailoring of the programme, access to and use of ART were hampered by the COVID-19 pandemic's disruption of HIV services and the ensuing lockdown measures, leading to non-adherence among MSM. The COVID-19 pandemic led some MSM to relocate, thus placing them out of the programme's reach. Hence, the need exists to implement various interventions to improve access to HIV services, including DSD models such as eHealth services, among others, as well as the provision of travel permission letters to MSM who are on ART during movement-restricted conditions. Moreover, investing in and classifying such interventions as essential services will ensure prioritisation and fewer disruptions in situations similar to the COVID-19 lockdown. This study has provided insights into the impact of the COVID-19 pandemic on MSM's access to HIV treatment services in the Capricorn District of Limpopo Province in South Africa. This is essential for future pandemic preparedness and contributions towards the 95-95-95 UNAIDS goals of ending HIV as a pandemic by 2030. Subsequently, future studies should investigate the impact of COVID-19 and similar pandemics on HIV services among MSM and other KP groups on a larger scale.

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Abbreviations

The following abbreviations are used in this manuscript:

MSM	Men who have Sex with Men
PLHIV	People Living with HIV
KPs	Key Populations
CFIR	Consolidated Framework for Implementation Research
COVID-19	Coronavirus Diseases 2019
SAMRC	South African Medical Research Council
ART	Antiretroviral Therapy
NDoH	National Department of Health
NPO	Non-Profit Organisation

Appendix A

Table A1. In-Depth Interview Guiding Questions on the Impact of COVID-19 on Access and Utilization of HIV Treatment Services Among Men Who Have Sex with Men in Capricorn District, Limpopo Province, South Africa.

Demographics
○ Age (in years), race (black, white, Indian, coloured, other: specify), education (none, primary, high school, tertiary), marital status (single, married, divorced, widowed), location (rural, semi-rural, semi-urban, urban)
Sexual Identity and Orientation
○ Which group of the MSM do you identify with? i.e., gay, bisexual, etc.
Impact of COVID-19 on HIV Care Services
○ Were your healthcare/HIV care needs and preferences met during the COVID-19 lockdown? Provide specific examples of which ones and how they were met.
○ Was the programme able to adapt to the changes brought by COVID-19 and ensure continuity of services during the COVID-19 lockdown?
○ What are the challenges and barriers to timely HIV testing, linkage to Care, ART refill, ART adherence, viral load tests, and making clinic visits during the COVID-19 pandemic? Be specific.
○ Have you ever felt like you needed psychosocial assistance/counselling services due to COVID-19 challenges? If yes, did you get the assistance from the programme?
○ Were you able to communicate with your healthcare providers during the COVID-19 lockdown? How?
○ What improvements would you recommend about HIV care services during the COVID-19 lockdown?
○ Any general comments on your experiences concerning HIV care services and COVID-19?

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