

# **WORKSHOP REPORT**

## **MSM Issues in African HIV and AIDS Response Global Learning, Local Solutions**

**Addis Ababa, Ethiopia  
1 to 2 December 2011**

**AMShEr  
African Men for Sexual Health and Rights  
[www.amsher.net](http://www.amsher.net)**

# **CONTENTS**

**ACRONYMS**

**EXECUTIVE SUMMARY**

**RECOMMENDATIONS**

- 1. INTRODUCTION**
- 2. PURPOSE AND OBJECTIVES**
- 3. CONTEXT**
- 4. A RIGHTS-BASED APPROACH**
- 5. RESEARCH ON MSM AND HIV**
- 6. PREVENTION AND TREATMENT**
- 7. FUNDING**
- 8. INFLUENCING POLICY CHANGE**
- 9. CHALLENGES**
- 10. PRIORITY ACTION AREAS**
- 11. CONCLUSION**

**ACKNOWLEDGEMENTS**

**RESOURCES**

## ACRONYMS

AIDS	Acquired Immunodeficiency Virus
AMShER	African Men for Sexual Health and Rights
ART	Antiretroviral therapy
CBO	Community-based organization
CCM	Country Coordinating Mechanisms for the Global Fund
DFID	UK Department for Foreign and International Development
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IBBS	Integrated Behavior and Biological Surveys
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MARPs	Most at-risk populations
MSM	Men who have sex with men
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TG	Transgender
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
VCT	Voluntary counseling and testing

## **EXECUTIVE SUMMARY**

Men who have sex with men (MSM) bear a major burden of the HIV epidemic. More than 80 percent of MSM in Africa do not have adequate access to effective HIV prevention and treatment services owing to adverse legal, social and health care environments. Most interventions are limited in scale, impeded by weak political commitment, punitive legal frameworks, policy barriers, discriminatory social environments, limited technical capacity, lack of resources and insufficient MSM-targeted research.

In the absence of open dialogue and evidence-based data on MSM, this population remains vulnerable and marginalized, and the impact of the epidemic on MSM in Africa is largely hidden. Committed to redressing this problem, African Men for Sexual Health and Rights (AMSHeR), a coalition of fifteen MSM and human rights organizations working to improve HIV response for MSM in Africa, facilitated a workshop from 1 to 2 December 2011 in Addis Ababa, Ethiopia. Representatives of human rights organizations and international agencies convened to collectively examine ongoing challenges and generate potential solutions.

Workshop participants agreed that universal access to a comprehensive package of services for MSM that span the prevention, treatment and care continuum is the ultimate goal for an effective HIV response. A combination of peer education and outreach; screening, management and treatment of STIs; access to prevention commodities; voluntary HIV testing and treatment; and a supportive psycho-social environment are vital components of a MSM response strategy, with targeted interventions of the appropriate scale and intensity.

Participants determined key action areas necessary to promote enabling environments for improved HIV response and to support the empowerment of MSM to claim their rights and articulate their needs in the context of HIV. These included defining strategic priority areas to overcome obstructive legislative and policy barriers, mobilize funding from international donors and governments, and effect reform of punitive legal frameworks and social stigma, as well as to strengthen MSM-oriented health services and rights-based programs.

Participants committed to strengthening a broad-based Pan-African network aimed at coordinating the work of MSM and human rights organizations across the continent and building strong partnerships with influential stakeholders, as well as mobilizing a critical mass of organizations and activists from the broader human rights movement to advocate for universal access to HIV prevention, treatment and care services. Under the auspices of this network, MSM will seek to proactively engage in policy decision-making, service design, implementation, and monitoring and evaluation of strategies and operational programs. Participants also committed to working together to ensure that official decision-making on resource allocation is transparent

and participatory, that MSM-directed services are scaled up, and the capacity of service providers to address the specific needs of MSM is strengthened.

Much remains to be done. Laws, policies and socio-political perceptions need to change to ensure that MSM in Africa benefit from effective HIV interventions and positive health services, and that they are able to exercise and claim their full rights as citizens, including the right to life, the right to health and the right to human dignity.

## **RECOMMENDATIONS**

### **Legal and Policy Reform**

- Promote the realization of universal human and sexual rights for MSM populations and advocate for a rights-based approach to inform all HIV-related policy frameworks, policymaking processes, and policy implementation.
- Scale up advocacy to repeal all laws that criminalize consensual same-sex relationships and to reform punitive legal frameworks, replacing laws that discriminate against sexual minorities with protective laws, in line with international human rights standards.
- Promote greater coordination between public health and justice sectors to undertake human rights-based judicial and policy actions to improve the legal and health policy environments for MSM.

### **Building Partnerships**

- Build broad-based networks with LGBTI and human rights organizations focused on combating discrimination and stigma against MSM and initiating dialogues with religious and community leaders to overcome adversarial social attitudes and negative social perceptions towards MSM.
- Conduct outreach and communication campaigns to sensitize mainstream populations on MSM and HIV issues, and establish strategic partnerships with the media to support broader civil society understanding of the role of human rights frameworks and standards in addressing the HIV epidemic.
- Under a Pan-African coalition, initiate dialogue and engagement with national governments aimed at encouraging them to undertake their obligation to develop policies to address the high disease burden of MSM populations, to improve HIV and public health service delivery and to allocate resources for MSM-responsive HIV programming and service delivery.

- Where feasible, facilitate collaboration between government and non-government sectors to promote substantive participation of MSM in HIV program design and execution, including at national and local levels.
- Strengthen advocacy and partnership with African governance bodies, including the African Commission on Human and People's Rights, to collectively pressure national governments to recognize MSM as an at risk population and to formulate effective policies to reduce their vulnerability to HIV.

### **HIV Programming**

- Design and disseminate interventions and program components for effective MSM-targeted HIV response, informed by accurate evidence and good practices.
- Establish demonstration and pilot sites as centers of service delivery excellence in countries where MSM interventions have not been implemented by governments.
- Create a favorable environment and scale up communication to support increased and sustained safe sex behavior and appropriate health seeking behavior amongst MSM communities, and increase access of communities to condoms and lubricants, and to services for HIV and STI testing, treatment, counseling and support.
- Promote the use of mobile technology as a channel to strengthen prevention and treatment practices and to offer education to vulnerable populations, and explore its potential as a tracking mechanism for clinical referrals.

### **Capacity-Building**

- Advocate for stronger capacity and skills amongst health service providers to respond effectively to MSM health needs, including diagnosis and treatment for STIs and vulnerabilities generated by sexual practices, and to provide a continuum of HIV prevention, treatment, care and support.
- Undertake capacity-building interventions aimed at combating homophobic attitudes towards MSM by health service providers, and encourage them to recognize that services and treatment provided to MSM should be humane, respectful and informed by medical ethics, ensuring that they are sensitized to respect the human rights of MSM and to maintain confidentiality of information.
- Scale-up training and outreach of peer educators, particularly in under-served MSM communities, to educate communities in prevention and treatment of HIV and AIDS, and tap into the creative energies and dynamism of youth as potential educators.
- Facilitate capacity-building of MSM organizations, particularly those operating at community level, to strengthen strategic advocacy skills and capacity to monitor and evaluate intervention outcomes and impact.

## **Resource Mobilization**

- Mobilize resources to scale up successful HIV prevention, voluntary counseling and testing, treatment and care programs for MSM through direct government grants, and work collaboratively with organizations that have experience implementing such programs.
- Ensure that comprehensive service packages for MSM include free distribution of condoms and lubricants; education and outreach projects, and a continuum of HIV and sexual health services.
- Work in partnership with international donors to facilitate increased and sustained resource flows and funding for MSM-targeted HIV programming and related advocacy work, and encourage donors to support country and organizational ownership of response, to ensure that the effectiveness of interventions is not compromised by reduced organizational autonomy.
- Take leadership in mobilizing resources through a range of creative approaches, including income generation activities, and develop innovative approaches to attracting resources that make use of all available information and communication technologies.

## **Research and Documentation**

- Formulate innovative approaches to overcome barriers to meaningful, accurate research in order to produce informed, qualitative research that can assist in better addressing the needs of MSM populations and understanding the diversity that exists within the MSM population.
- Better design and conduct meaningful research on HIV amongst MSM in challenging social, political and human rights contexts, undertake focused research to determine the impact of HIV on MSM populations, and monitor in which direction the epidemic is moving amongst MSM through the use of behavior indicators and integrated behavior and biological surveys.
- Work with research institutions to collectively undertake studies to provide a scientific evidence base for targeted HIV prevention, treatment and care interventions, and ensure that behavioral messages generated there-from translate into improved prevention action by MSM.
- Scale up documentation of best practices in HIV interventions, care and advocacy related to MSM work in rights-constrained environments, and communicate these to necessary stakeholders through broad-based communication platforms, including internet-based chat rooms, communities of practice, blogs and social marketing sites, as well as mobile phone technology.

## **1. INTRODUCTION**

A workshop on “MSM Issues in African HIV and AIDS Response: Global Learning, Local Solutions” was facilitated by AMSHeR on 1 and 2 December 2011, in Addis Ababa, Ethiopia. Representatives of international agencies and African organizations working on HIV policy and technical issues affecting MSM populations convened to engage in dialogue on critical issues impacting on their advocacy and programming to improve HIV response for MSM in Africa, and to determine key actions and solutions to ongoing contextual and biomedical challenges facing MSM populations on the continent.

The workshop focused on exploring key challenges facing MSM in the HIV response, including stigmatization and criminalization of MSM; political and social denial that same-sex relationships take place; inadequate and unreliable epidemiological information on HIV transmission through male-to-male sex; difficulty reaching MSM, particularly those who do not self-identify; lack of awareness or sensitivity amongst health care practitioners and hospital staff about the existence or needs of MSM; and reluctance of donor agencies to support MSM programs on HIV and AIDS.

Workshop participants identified priority interventions necessary for a rights-based HIV response for MSM in Africa, emphasizing the need for legal and policy reform; advocacy to overcome stigma and hostile societal attitudes; mobilization and sustainability of resources; and epidemiological and behavioral research specific to the needs of MSM. In order to deliver on these action areas, participants committed to strengthen multi-stakeholder collaboration through the parameters of a broad-based Pan-African network of MSM and human rights organizations aimed at securing universal access to effective HIV and AIDS prevention and treatment services.

## **2. PURPOSE AND OBJECTIVES**

Under the leadership of AMSHeR, the workshop brought together a diverse range of participants to develop guiding principles aimed at strengthening African MSM and sexual health networks and to identify challenges and action areas for targeted and coordinated advocacy to improve HIV response. The workshop provided an opportunity for participants to share personal experience and articulate professional concerns around safety in the context of adversarial legal, political and social environments, direct programming to provide a continuum of prevention, treatment, care and support for MSM, and advocacy for improved government HIV response for vulnerable populations.

The following objectives informed the workshop:

- Consolidating participants' understanding of the factors that shape HIV prevalence and response for MSM in Africa, including issues around policy, resources and service delivery.
- Familiarizing participants with the key elements of an advocacy and policy action plan.
- Sharing participants' knowledge in collecting HIV-related evidence for MSM.
- Familiarizing participants with the role of data in advocacy, including different types and sources of available data.
- Identifying components of intervention plans and essential service packages for MSM.
- Enhancing participants' understanding of issues of sexual rights, sexuality, gender and their interplay with MSM issues.
- Strengthening the functioning of the African MSM network through reaching agreement on effective communication and coordination mechanisms, and defining roles, responsibilities and participation in the network.
- Identifying resources that the African MSM network requires to support its advocacy and partnership work.

### **3. CONTEXT**

In the majority of African countries, same-sex orientation as a human right is denied. Sexual difference and, in particular, LGBTI sexual orientation, is used as a basis for political exclusion, social marginalization and legal criminalization. 38 of 53 countries in Africa criminalize sexual relations between men, with “sodomy laws” and a punitive legal framework often taking on the force of vigilantism leading to repression, torture and abuse of MSM. In some countries, MSM face the death penalty. Human rights violations are rampant across the continent and access to justice non-existent, including for MSM activists and human rights defenders.

In this climate of institutionalized homophobia, discrimination in provision of basic health services and lack of access to health-promoting information puts MSM populations at particular risk of contracting HIV and of suffering disproportionately from its consequences. HIV and AIDS prevalence remains high among MSM in Africa, although there is a clear paucity of data on incidence in the region. Restrictive legal or policy environments and discriminatory social attitudes hamper collection of epidemiological and behavioral data. Case reports, statistics and prevalence data are inadequate in guiding substantial response to the epidemic and informing necessary resource allocation for prevention among different at-risk populations.

HIV program delivery by government tends to be limited as few countries have included MSM as a vulnerable group with their HIV and AIDS Strategic Plans. In Sub-Saharan Africa there are few government-executed programs to combat HIV and AIDS specifically among MSM. Access to basic resources and services are limited, and HIV issues, particularly those related to MSM, are not mainstreamed in public hospitals. South Africa is an exception: its Constitution includes sexual orientation as a basis for protection and same-sex marriages are legally permitted. It specifically targets LGBTI as vulnerable populations in its National Strategic Plan and its operational plan for MSM-specific intervention has been drafted by the National AIDS Council's LGBTI Sector. Its public health system, however, requires strengthening and sufficient resources to deliver quality health services to all. Inequitable and unaffordable health service delivery characterizes public health systems across the continent, and is a key obstacle to effective HIV response.

Despite these challenges, workshop participants expressed the progress their organizations are making in advocacy for improved public service delivery of essential medicines and commodities, strengthened biomedical intervention, sensitization of MSM populations on prevention practices, provision of psycho-social support, and training of peer educators to offer lifestyle management guidance to vulnerable communities, including nutritional advice for MSM living with HIV. Participants are proactively continuing to develop partnerships, capacity, data and funding for HIV prevention, treatment care and support for MSM, and to reduce HIV incidence among MSM through strengthening community interventions through frontline programming.

#### **4. A RIGHTS-BASED APPROACH**

Workshop participants agreed that HIV interventions for MSM must be modeled on a rights-based approach that protects, promotes, respects and fulfils the rights of all individuals. MSM, including those living with HIV, should have universal enjoyment of human rights: the right to equality and non-discrimination, the right to recognition before the law, the right to life, the right to security of person, the right to privacy, the right to freedom from arbitrary deprivation from liberty, the right to health, and all other civil, political, socio-economic and cultural rights. In adherence to international human rights law and standards, all individuals should be afforded equitable access to health services, without prejudice and discrimination.

A rights-based approach affirms the fundamental freedoms of MSM, in particular, freedom to express sexual orientation without fear and repression, and recognizes that provision of HIV services alone does not meet the health needs of MSM or constitute an effective response to the HIV. A broad-based sexual health approach for MSM that promotes positive health and human dignity is necessary. This requires acknowledging the rights of MSM to receive the

range of services specific to their needs, including counseling on relationships, self-esteem, body image, sexual behaviors and functioning, and specific STI services.

Further rights-oriented action demanded by this approach includes active engagement by justice ministries in mainstreaming human rights in all government decision-making processes and policies, sensitization of law groups and law enforcement officers, and review of constitutional provisions relating to marginalized groups, and makes way for their inclusion in generalized policymaking and HIV-specific planning. It further involves capacity building of vulnerable groups to know and claim their rights and to take recourse action in the event of violation of their rights.

A rights-based approach to the sexual health needs of MSM should take into account the World Health Organisation's definition of sexual health, addressing also the rights to privacy and freedom of association, and should repeal any and all laws, regulations and policies that impede the right to sexual health for all. Criminal sanction and discriminatory policies further marginalize an already vulnerable population and impedes MSM from actively and freely accessing information and health care services. Lack of support structures and safe spaces generates further isolation of MSM and causes psychological trauma and distress.

## **5. RESEARCH ON MSM AND HIV**

Workshop participants affirmed that more extensive and accurate biological and epidemiological research is required to assess the burden and trends of HIV among MSM in Africa. Such research should include baseline surveys, case reports, bio-behavioral surveys and incidence data. In its absence, the prevalence of HIV infection amongst MSM is difficult to determine. Operations data is needed to inform programming and to track and evaluate the progress of program execution and service delivery.

Potential barriers to conducting meaningful research among MSM in African countries include:

- Measures, surveys and instruments that may be culturally inappropriate for use with MSM;
- Interviewers who are not race and gender-concordant or sensitive to the local cultural, ethnic and gender context;
- Instruments that use language and terminology that does not resonate with MSM or with the context;
- Research settings that may not be conducive to open discussions with MSM;
- Stigma resulting in unwillingness of MSM to disclose their sexuality and needs for fear of discrimination, therefore making it difficult to recruit representative samples of men who engage in same sex relationships;

- Limited capacity and resources to conduct targeted research focused on generating, analyzing and effectively utilizing data and information to inform program planning and operations.

Operations data need to include vulnerable population size estimations, response mapping, project evaluation, and program coverage assessment. In some countries, PEPFAR is funding operational research, including surveys on biological and social activities of MSM, with technical working groups coordinating efficient use of funding and research interventions, and determining guidelines and standards for collection of data.

Participants stressed the need for research partnerships between civil society, government departments, research institutions and academia. Field researchers must take into account the need to ensure confidentiality in the research process and to build credibility and trust with MSM organizations and populations. In this context, the involvement of MSM in research initiatives is crucial, in particular in conducting needs assessments in communities. Dissemination of research findings and results should be timely and should be produced in a suitable and accessible format.

Participants concluded that despite sophisticated national HIV strategies in place in many countries, the slow pace of implementation and service delivery, and significant gaps translating research outcomes into results-based programs informed by the diverse needs of MSM are weakening HIV response. In addition, it is evident that further research and data collection is needed to inform targeted HIV prevention, treatment and care interventions and to encourage open dialogue on these issues, regardless of the legal environment concerning same sex relationships. In addition, it is critical to conduct research and collect evidence in countries where the environment for MSM and people living with HIV is more inhospitable, in order to evaluate the effect of stigma on public health and to determine the mechanisms for intervention and redress.

## **6. PREVENTION AND TREATMENT**

MSM carry a high HIV burden and innovative approaches are required to reduce prevalence. A comprehensive package of services for MSM infected and affected by HIV and AIDS must include:

- General psycho-sexual and psycho-social counseling;
- HIV counseling, testing and treatment;
- Free distribution of condoms and water-based lubricants;
- STI screening and treatment;

- Treatment for HIV, provision of ART and monitoring of CD4 counts and HIV viral loads.

Aggressive intervention is needed where HIV prevalence has reached high levels, requiring the following:

- Increased uptake of testing, while maintaining confidentiality
- Universal access to pre-and post-exposure prophylaxis
- Structural and institutional interventions to support rapid behavioral changes.

Strengthening the capacity of health providers to address all conditions related to the sexual health of MSM is critical. Providers must be trained in both medical and psycho-social intervention. MSM should have full understanding of biological and other factors that place them at risk of HIV transmission, and of the safest commodities to assist prevention, including the use of water-based lubricants and avoiding lubricants that contain forms of anesthetic. Engagement in transactional sex, multiple concurrent partnerships amongst MSM, unstable relationships where partners do not use condoms in sexual relations, or dependence on income-earning persons who become principle decision makers regarding sexual practice increase vulnerability. Circumcision, which is not sufficiently discussed in MSM community, may provide some protection against transmission; however, use of condoms should be continued even if partners have been circumcised.

A range of approaches to prevention and treatment for HIV and AIDS relevant to MSM exists. Rectal microbicides, currently undergoing vigorous efficacy testing, are a promising prevention tool. In addition, there has been a 96 percent reduction risk of HIV transmission in HIV-discordant couples upon initiation of ART. Post-exposure prophylaxis (PEP) may be used to prevent acquiring HIV after potential exposure, but should be started no later than 72 hours after exposure and continued for a period of thirty days. Countries have been slow to issue specific guidelines on the use of PEP, except in the incidence of rape, and there is a slow uptake in the use of PEP among MSM. Insufficient research has been conducted on the efficacy of PEP after rectal exposure to the virus, where there is a higher efficiency of transmission, possibly owing to easier tissue penetration. Pre-exposure prophylaxis (PrEP), being the first biomedical intervention with specific efficacy for MSM, may be used before an anticipated potential exposure to HIV to prevent acquiring the virus. The PrEP efficacy trials showed that these drugs can greatly reduce the risk of HIV transmission, especially among MSM. However, stigma, homophobia, and criminalization, to name a few, pose as major barriers to delivering PrEP to MSM. Targeted information campaigns are needed to promote awareness of PrEP and other emerging strategies among MSM and their providers prior to implementing these strategies. Doing so will likely increase acceptability of PrEP and make it a more feasible public health intervention.

Questions concerning resistance in the long-term to the use of ART as a prevention tool remain and whether the use of PrEP increases the risk of drug resistance or sero-conversion. There is also concern among MSM around the long-term side effects of ART, as well as the lack of supportive environment for new take-up of ART, resulting, in some cases, in poor adherence.

Condoms should be freely available and accompanied by lubricants, which should be at the correct PH concentration (noting that if osmolarity is incorrect, lubricants can be damaging and raise rather than lower transmission risk). In South Africa condoms are free and the government is currently issuing tenders for lubricant suppliers, which will also be free: a good indication that the government is taking responsibility for distribution and effective prevention.

The general lack of experience and skills among medical practitioners and other health service providers remains a key problem in the health care system. A chronic lack of awareness of the sexual health issues of MSM continues to exist among providers and homophobic attitudes may result in degrading treatment of MSM attempting to access services. Questions asked at healthcare facilities in order to determine treatment are frequently inappropriate and irrelevant. This hinders communication and faith of MSM in the health care system.

In the absence of government action, it is important for organizations to establish clinics equipped with skilled health care workers, in order to facilitate free communication and correct prevention and treatment protocols that are evidence-based and epidemiologically proven, and to establish safe and empowering spaces for MSM to access services.

It should be noted, however, that governments are obliged to provide equitable accessible quality health care to all members of the population, and that the responsibility for ensuring that health service providers are correctly skilled and sensitized to the health needs of MSM and other vulnerable populations lies with the government.

## **7. FUNDING**

Participants confirmed that accessing and sustaining funding for advocacy and programming is of high priority. Currently, they are experiencing significant funding cuts from international donors, amounting, in some countries, to a resource crisis. Participants stressed the paucity of government funding for HIV initiatives targeted at MSM, and their failure to support NGOs' work in filling the gap in government service delivery. Advocating for change is necessary, as securing government funding is the best guarantee for sustainability for NGOs' work.

A challenge facing many national organizations is the allocation of international funding, particularly from US-based donors and funding mechanisms such as PEPFAR. Resources tend to be allocated to US-based organizations or US-initiated research projects that are executed within African countries. This trend is disempowering to national NGOs and CBOs and impacts on long-term sustainability and ownership of programming by organizations. Some donors are also sidelining NGOs in favor of providing technical support to governments, including in countries where governments are clearly hostile towards MSM-focused organizations. Governments are continuing to pressure PEPFAR for funding as a revenue source, without offering results-driven, cost effective programs or clear targets. In addition, funding is primarily allocated to prevention services, rather than to the continuum of response, from prevention to treatment, care and support. Another critical HIV funding source, the Global Fund for HIV/AIDS, Tuberculosis and Malaria does not prioritize MSM-related funding. This requires urgent redress. It is critical that MSM organizations participate in Country Coordinating Mechanisms for the Global Fund, so that their voices may be heard and their issues articulated at decision-making levels.

Participants noted that in the current resource-scarce environment, it is essential that organizations employ creative and flexible fundraising methods. These include forming solid relationships with diverse stakeholders, including national AIDS councils, planning commissions, UN bodies and national health ministries. It is also essential to be aware of donor priorities and constraints. This requires forming strong relationships with targeted donors, identifying potential supporters and key individuals within donor organizations, and establishing credibility through efficient utilization of funds and strong auditing processes. It is also important to monitor donor policy and policy windows of opportunity. Developing an extensive background on donor policy will assist organizations in orienting their communication to suit donor priorities and language.

The use of results-based programming and integration of monitoring and evaluation (M&E) processes into fundraising proposals and organizations' advocacy and programming work is an important means of proving impact to donors and thereby attracting and sustaining funds in the long-term. Although evaluation of qualitative versus quantitative change may be difficult in this process, it is nevertheless important to document qualitative progress and behavioral change, and to use creative tools in compliance with this process. These may include conducting surveys, gathering recipients' and community members' testimonies, staff profiles and interviews, recording community dialogues, as well as employing traditional M&E tools. It is also important to construct baselines prior to commencing programs and advocacy initiatives, in order to have a clear instrument against which to measure progress.

The most effective strategies are those where organizations plan-and-act on an ongoing basis, monitoring actions, evaluating success, and learning from evaluations, and continuing to plan-and-act. The following questions should inform the process evaluation:

- What is the logic or theory of change informing the intervention?
- What activities were implemented and were they implemented as planned?
- Who has the intervention reached and what is the extent of the program coverage?
- What is the level of quality of services and commodities provided?
- What is the level of satisfaction of beneficiaries?
- What are the strengths and weaknesses of the individual interventions and the overall program?

Outcome evaluations should also be conducted, examining differences in changes over time with regard to correct knowledge of HIV transmission and prevention; consistent use of prevention commodities; occurrence of STIs; seeking STI services; and seeking CT services.

Such data and general documentation may also assist the compilation of best practices that should be shared between organizations to improve advocacy and programming, and can inform a collective narrative for use when attracting resources and mobilizing funding. This should accompany accurate donor reporting according to established timelines, and submission of financial audits to assure donors that funds are being efficiently spent. In this context, transparency boards that open up financial statements to public scrutiny may be useful.

## **8. INFLUENCING POLICY CHANGE**

Participants recognized the need to influence policy and decision-making processes more effectively to ensure that policies address their needs and are based on sound research and evidence, thereby improving health outcomes for MSM.

Successful policy influence depends on five inter-related factors:

- (1) A coherent and feasible strategy based on sound contextual analysis;
- (2) Accurate influence maps identifying individuals and groups with the power to effect key decisions;
- (3) The extent and functionality of established networks, alliances and coalitions with likeminded stakeholders;
- (4) Level of political and legal understanding and knowledge of how policy decisions are made;

- (5) Ability to leverage knowledge and communication technology;
- (6) Building a convincing case for policy change and presenting clear policy options to political and legal actors, and to other stakeholders.

It is necessary to recall that advocacy is a proactive and long process, requiring extensive networking, relationship-building, presence at key consultations, and consistent lobbying, as well as nurturing and maintaining constructive relationships with government and non-governmental targets.

The choice of advocacy approach is critical. Confrontation seeks to obtain change through pressure and to point out problems rather than offer solutions, working from the outside policy communities. High-profile, confrontational strategies and public campaigns, although often backed by sound research and evidence, may not be the most useful tool for policy change, particularly with adversarial governments. A more effective approach may be for MSM organizations to work collaboratively with policy-makers, to channel new ideas and to lead creatively and constructively. This approach involves building strong working relations with policy-makers, aimed at advising, monitoring and leveraging policy change.

Advocates and policy influencers may interact with policy-makers through official policy working groups or through loose networks of actors interested in sharing ideas, where the links between them may be formal or informal. Before determining their action plan in leveraging this process, they must answer the following questions:

- Who are the principal policy-makers?
- Who are the key stakeholders?
- What links and networks exist between them?
- Who are the intermediaries and do they have influence?
- Who are the main international actors in the policy process and what influence do they have?
- Is there a policy-maker demand for new ideas?
- What sort of evidence will convince policy-makers?
- What are the sources/strengths of resistance?
- What is the policy-making process?
- What are the opportunities and timing for input into formal processes?

To effect desired change, it is important to recognize that policy influence is played out in the interface of the following factors and that successful advocacy involves fluid navigation and manipulation of all factors:

- External influences: socio-economic and cultural influences; donor policies
- Political context: policy-making processes and planning cycles
- Links: lobbying, networking and media engagement
- Evidence: research, analysis and learning

## **9. CHALLENGES**

### **Restrictive Legal and Political Environments**

Prohibitive legal frameworks and punitive laws regarding same-sex relationships cause MSM to “go underground” and to avoid accessing prevention and treatment services for fear of intimidation or arrest. These laws result in torture and inhuman treatment of MSM by law enforcement officials and social exclusion within their communities. MSM organizations are forced to remain invisible and to ensure that all information is hidden and is non-accessible to the police and vigilante groups intent on brutalizing or harassing identified MSM. This obstructs effective and sustainable responses to HIV among MSM populations. Structural changes to legal and social environments and mobilization of sufficient resources are particularly difficult in countries with little government ownership of HIV response for MSM populations or political will to implement effective intervention measures.

### **Social Stigma**

Social perceptions that sexual relations between men are a violation of religious and natural laws and that non-heteronormative sexual practices are contraband has resulted in many MSMs being viewed as social deviants, failing to comply with socially constructed rules of masculinity. Destructive consequences include rejection of MSM by their families, exclusion by religious and traditional leaders from their communities, punitive rape, extortion, and constant societal surveillance and policing. Many medical professionals consider homosexuality an illness, although the World Health Organization has declassified it as a pathology, emphasizing that clinical research reveals homosexuality to be a natural genetic variation in the human condition. Substance abuse and suicide rates remain high comparative to mainstream populations, resulting from consequent loss of dignity and self-esteem. Many MSM feel they have to be extra-productive to prove their worth as members of society, which takes a physical and mental toll on their wellbeing. Double stigma may result for MSM who disclose a seropositive status. Stigma therefore remains a critical obstacle to effective HIV response as many MSM avoid accessing testing and treatment sites, or may disguise themselves as heterosexual to receive services.

## **Lack of Resources and Capacity**

In many African countries, government resources are not specifically directed towards addressing MSM concerns and providing health services responsive to MSM populations infected and affected by HIV and AIDS. Government decision-making regarding resource allocation and the scale up or down of services is non-transparent and non-participatory. Government funding and programming remains poor, accompanied by decreasing funding flows from international donors, including the Global Fund, PEPFAR, USAID and DFID. In resource-constrained environments, institutions and organizations therefore have limited resources and capacity to conduct HIV programming and advocacy initiatives. This is compounded by unskilled health care workers and service providers, as well as CBOs that are unable and unwilling to identify, assess and manage issues related to the sexual health of MSM. The capacity of health service providers is largely insufficient to address the diverse needs of MSM. This limits the access of MSM to appropriate HIV testing and treatment and STI services.

Collaboration between government and non-government health sectors is poor. The importance of engaging MSM in service design, implementation and evaluation, as well as in procurement and distribution of medicines, supplies and prevention commodities is frequently unrecognized by decision-makers in the public health sector. This results in significant access barriers specific to HCT, ART, IEC, STI services, outreach, condoms and water-based lubricants as key prevention tools.

## **10. PRIORITY ACTION AREAS**

### **Legal Reform**

Recognizing that a wide range of MSM-specific repressive laws obstruct work on HIV among MSM, including sodomy and public assembly laws, a supportive legal and regulatory environment is essential for effective HIV response. Urgent legal and regulatory reform is therefore needed in many African countries, replacing punitive legal frameworks with facilitative and protective laws, such as antidiscrimination laws and decriminalization of homosexuality. This may be informed by thorough government review to understand the negative impact of laws on HIV prevention among MSM and, specifically, to identify laws that require immediate reform. Those governments currently contemplating the criminalization of homosexuality should reverse this process and recognize, on the basis of sound expert knowledge and research, that the consequence thereof is destructive to national societies and to effective HIV response. In addition, international human rights law and international instruments require governments to enact legislation that protects the rights of all individuals, regardless of sexual orientation. This requires governments to rescind laws criminalizing

same-sex relationships. Key advocacy targets for the creation of positive and empowering laws include national Ministries of Justice, parliaments and national law-makers.

### **Overcoming Stigma**

Recognizing that decriminalization alone will not lead to reduced discrimination, it is imperative that socio-cultural stigma is overcome. As the situation in South Africa shows, although MSM in the country are protected by the world's most robust and human rights-based constitution, social perceptions of MSM are still negative and marginalization remains a reality for many MSM. Initiation of dialogue and ongoing engagement with religious and traditional leaders by MSM organizations is key to addressing this issue. Identifying positive role models as rights defenders who will speak in support or on behalf of the MSM population and will provide support in sensitizing communities and broader societies on human rights and MSM issues is also important.

### **Mobilization and Network-Building**

Organizations will leverage more effective policy influence and public advocacy through coordinated alliances and functional networks that amplify collective voices and target key stakeholders to effect change. This includes alliances with vulnerable groups, health service providers, national health departments, and human rights organizations. A strong network acts as a focal point in creating a critical mass of activists and a secure space for MSM advocates to publicly engage on issues of concern and to hold meetings with stakeholders, employing the services of intermediaries, if necessary. Building an advocacy network that incorporates wider populations, including the women's movement, is a strong channel for sexual rights advocacy. MSM care networks are particularly important for non-reachable MSMs and those engaging in home-based care. Care networks are well placed to facilitate peer education and to establish empowered "buddy systems" of support, as well as to bolster referral processes.

### **Establishing Partnerships with Government**

Advocacy should move away from viewing government as a hostile enemy and employing name and shame approaches to more collaborative approaches. This includes advocating and supporting governments in service scale-up and improved grassroots delivery of essential health services, as well as lobbying national departments of health for increased technical units within departments. Governments, as principal duty bearers, must take responsibility for providing universal services and health care commodities to all sectors of the population, and must take long term ownership of HIV and AIDS programming for vulnerable populations. This requires identifying potential government allies and, with their support, initiating

mainstream government campaigns to sensitize political leaders and government officials to the importance of integrating MSM as a vulnerable population into government standards and to increase political commitment to change.

### **Peer Education Programs**

Peer educators help build MSM empowerment through peer education sessions and by enabling MSM to meet regularly in comfortable and safe settings that encourage freedom of expression among MSM so that they share information, become more knowledgeable and empowered to manage their health. High numbers of peer educators must be capacitated and trained to provide HIV and STI prevention and safer sex education to MSM through outreach and education that reach both visible and hidden MSM. Educators should communicate information and activities on risk assessment and reduction, and incorporate positive prevention messages for MSM, including prevention and treatment for STIs, encouraging treatment-seeking behavior, protecting partners from transmission, negotiation skills, and the link between HIV and drug use. Outreach can be provided at popular MSM gathering spots and recreation centers. It is necessary that peer educators receive regular trainings and skills building opportunities to improve outreach efforts, ensure accuracy of information and maintain interest and commitment. Training youth as peer educators has proven to be particularly beneficial as a means of harnessing their dynamism and energy towards community welfare. Resources permitting, drop-in centers should be established that cater specifically for MSM and are well stocked with condoms, lubricants and relevant education materials. These centers are well-placed to provide peer educator-facilitated support groups that can provide information, counseling, voluntary testing, and ART for seropositive MSM.

### **Treatment Literacy**

MSM have the right to equal access and quality of information and services that are received by other populations on HIV care, support and treatment. Community-run treatment literacy campaigns should aim to enhance access to accurate information on HIV care, support and treatment, as well as positive prevention for MSM living with HIV. Literacy manuals are useful tools to educate and train MSM living with HIV, health care workers, peer educators and their trainers on HIV treatment specific to MSM populations. In this context, it is important to note that treatment literacy goes beyond information dissemination; its focus is on enabling and empowering people to understand for themselves why behavioral change and adherence to treatment is important and to take positive action to ensure their own wellbeing. This involves direct engagement with seropositive MSM to understand the impact of having to complete

their drug treatments so that there is no chance of developing drug resistance to their medication. The approach requires interactive education, workshops, and mentoring from peer educators. Treatment literacy also elevates the level of general community knowledge about HIV, and strengthens the capacity of communities to engage in informed discourse and monitor advocacy around programs.

## **Communication and Outreach**

Effective communication initiatives are essential for community sensitization of health issues relating to HIV and AIDS, human rights and MSM. All forms of communication technology should be harnessed. Mobile technology is an effective tool for communication and has become increasingly important for organizations seeking policy influence, accompanied by judicious use of traditional forms of evidence gathering to inform policy. In addition, MSM organizations should cultivate relationships and establish partnerships with the media. Noting the reality of state-sponsored media propaganda aimed at perpetuating societal homophobia, working with media allies is an important means of ensuring accurate, timely, creative messaging. The media is a powerful channel to change negative perceptions and attitudes towards MSM and to raise general public and vulnerable populations' awareness of human rights, sexual health issues and positive health lifestyles. Reporters may be interested in undertaking training on issues related to MSM and HIV, which MSM organizations could facilitate.

Another powerful medium for positive messaging, countering homophobia and supporting empowerment among MSM is film as a form of edutainment. Film can assist in encouraging MSM populations to claim their human rights and may be a strong source of empowerment. Through its high media profile and public film reviews, it can creatively address the lack of visibility for MSM and their issues, and encourage positive debate amongst audiences in an engaging rather than hostile space. Film can also serve as a more subtle advocacy tool by targeting multiple stakeholders through creative story-telling. Film screenings provide a gravitational point for these stakeholders and LGBTI populations to engage with each other and potentially work together. Film also provides a platform for networking and connecting with diverse populations, including in rural areas, where populations have limited access to visual images and where MSM and their issues are more invisible than in urban areas.

## **Dialogue with Transgender Populations**

Transgender (TG) populations have been neglected in research and programming, particularly in West Africa, where their needs remain unaddressed. Many TG populations believe that their concerns are dominated by LGB issues and that they are marginalized as a result. The need to "break the silence" on transgender identity, needs and issues, remains critical to effective HIV

response. At the same time, forcing a transgender identity on persons must be avoided unless persons identify themselves as such. The general populace is largely uneducated on TG issues. As with MSM, health service providers are unskilled in addressing TG needs. Dialogue may serve to assist this process and may facilitate planning and risk assessments for HIV among TG populations, as well as ensure that mechanisms are put in place to lower transmission risks. As with the MSM population, further research is needed on the role of TG populations in HIV transmission and on behavioral trends amongst this vulnerable population.

## **11. CONCLUSION**

Ultimately, workshop participants were compelled to ask whether HIV and AIDS programming is failing same sex-practicing people in Africa. The answer, on many fronts, is affirmative. The punitive laws existing in many African countries are resulting in government inaction and official denial of the existence of MSM, entrenched social stigmatization, brutality and repression of MSM by law enforcement officers, and reluctance by organizations or health service providers to work with MSM. The criminalization of same sex relationships is contributing to the HIV vulnerability of MSM by forcing them to conceal their sexual orientation and to avoid health facilities for fear of harassment. Even in countries where protective laws exist, such as South Africa, the legal protection of the MSM population does not automatically produce social equality.

MSM, as rights-holding citizens, must demand greater accountability from national governments and continental governance bodies, including the African Union and Pan-African Parliament, to develop protective legislation and to improve and implement all sections of relevant policies and laws. In addition, national parliaments must be recalled to their purpose of holding government departments accountable in their execution of HIV and AIDS policies and strategies and to ensure that they integrate the needs of all citizens.

Participants concluded that factors influencing an effective response to HIV among MSM must include an enabling legal framework, a supportive social and political environment, adequate resources and capacity, and knowledge and information gathering and dissemination, with consistent and accessible messaging on prevention methods and new biomedical information. The needs of MSM are different from those of other populations and should be addressed through the provision of appropriate HIV and STI services that are available across the spectrum of prevention, treatment, care and support. Technical assistance needs and open channels for provision of quality technical assistance are critical. The complexities of sex, gender and HIV require further study of human sexuality as a continuum of the shifts and changes inherent in sexual identity. It also requires social understanding that the identity of MSM cannot be reduced to sexual activity alone. Same-sex sexuality is part of the sexual

repertoire of African men, regardless of its legal status. As such, the usefulness of MSM as a concept may change.

Participants committed to becoming change-makers in scaling up their struggle to combat homophobia amongst politicians, law and policy-makers, mainstream society and religious leaders. They reiterated the need to serve as empowered role models in their communities with intent to debunk stereotypes and social myths about MSM and to challenge constructs of masculinity in Africa, and to scale up Pan-African advocacy and campaigning for an improved African response to HIV and its effects on MSM.

## **ACKNOWLEDGEMENTS**

### **AMShE R Steering Committee**

Danilo da Silva  
Macdarling Cobbinah  
David Kuria  
Dawie Nel  
Friedel Dausad  
Gift Trapence  
Ifeanyi Orazulike  
Peter Njane

Joseph Sewedo Akoro  
Samuel Matsikure  
Dr Paul Semugoma  
Dr Steave Nenamde  
Parfait Behen  
Tony Gatore  
Jean Harve Buete

### **AMShE R Staff**

Joel Gustave Nana: Executive Director  
Kene Esom: Policy Coordinator: Law & Human Rights  
Tendai Thondhlana: Research and Policy Team  
Mtinkheni Munthali: Communications Team  
Thembi Tshabalala: Head of Operations and Finance  
Thabani Khazi: Performance Management Officer

### **Workshop Planning Committee**

Joel Nana  
Rajiv Dua  
Ronald MacInnis  
Friedel Dausad  
Tendai Thondlana  
Joseph Sewedo Akoro  
Peter Njane  
Danilo da Silva  
Mac-Darling Cobbinah

### **About AMShE R**

African Men for Sexual Health and Rights (AMShE R) is an African coalition of 15 HIV and human rights organisations sharing a vision of an empowered and healthy life for African men who have sex with men, with human rights for all. AMShE R is currently made up of 15 organisations from 13 countries and is in communication with allied advocates and

organisations throughout the African continent and globally to ensure the achievement of coalition objectives.

## **RESOURCES**

UNAIDS Action Framework for MSM and TG People

Desmond Tutu HIV Foundation: MSM, An Introductory Guide to Health Workers in Africa  
[http://allen.org.za/hiv/MSM\\_manual4.pdf](http://allen.org.za/hiv/MSM_manual4.pdf)

World Health Organization Guidelines on the Prevention and Treatment of HIV for MSM and TG Populations  
[http://www.who.int/entity/hiv/pub/guidelines/msm\\_guidelines\\_annexes.pdf](http://www.who.int/entity/hiv/pub/guidelines/msm_guidelines_annexes.pdf)

World Health Organisation: Guidelines for the Management of STIs  
[www.who.int/hiv/pub/sti/pub6/en/](http://www.who.int/hiv/pub/sti/pub6/en/)

International HIV/AIDS Alliance Peer Education Manual  
[www.aidsalliance.org/includes/Peer\\_education\\_manual.pdf](http://www.aidsalliance.org/includes/Peer_education_manual.pdf)

Amnesty International Campaigning Manual  
<http://web.amnesty.org/pages/campaigning-manual-eng>

Institute for Global Communications: Advocacy Tips for Nonprofits  
[www.igc.apc.org.html/advocacy.html](http://www.igc.apc.org/html/advocacy.html)

Johns Hopkins University: "A" Frame for Advocacy  
<http://www.jhu.edu/-tsp/publicat.htm>