



USAID
FROM THE AMERICAN PEOPLE



PEPFAR

U.S. President's Emergency Plan for AIDS Relief

AFRICA REGIONAL WORKSHOP ON HIV PROGRAMMING FOR MEN WHO HAVE SEX WITH MEN (MSM)

HIV Prevention, Care, and Treatment for MSM: A Review of
Evidence-Based Findings and Best Practices

February 14–16, 2012, Johannesburg, South Africa



AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

OCTOBER 2012

This publication was made possible through the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development under contract number GHH-I-00-07-00059-00, AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I.

AFRICA REGIONAL WORKSHOP ON HIV PROGRAMMING FOR MEN WHO HAVE SEX WITH MEN (MSM)

**HIV PREVENTION, CARE, AND TREATMENT FOR
MSM: A REVIEW OF EVIDENCE-BASED FINDINGS
AND BEST PRACTICES**

**FEBRUARY 14–16, 2012, JOHANNESBURG, SOUTH
AFRICA**

AIDS Support and Technical Assistance Resources Project

AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

Recommended Citation

Dadian, Margaret. *Africa Regional Workshop on HIV Programming for Men Who Have Sex with Men (MSM)*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Acknowledgments

This meeting was organized by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Office of the Global AIDS Coordinator, with additional support from the U.S. Centers for Disease Control and Prevention and the U.S. Agency for International Development, with support from PEPFAR's Technical Working Group for most-at-risk populations. The organizers would like to acknowledge all of the support that ensured this meeting's success:

Technical design: The following organizing committee members were heavily involved in the meeting's design and implementation: Richard Needle, Michael Calabria, Billy Pick, Cameron Wolf, Laurel Rushton, Mary O'Grady, Gaston Djomand, Abu Abdul-Quader, A.D. Mc Naghten, Sasha Mital, Carlos Toledo, Brian Rettmann, Richard Poole, and Reepsina Chintalova-Dallas.

Advisors to the organizing committee, chairpersons, presenters, small group facilitators, and resource persons: George Ayala, Krista Lauer, Kent Klindera, Owen Ryan, Wendy Benazerga, Christina Chappell, Gary Svenson, Chris Collins, Gail Andrews, and Marina Rifkin.

Administrative support: Amy Pepin.

Cover Photo:

Photo is from the workshop presentation by James McIntyre, ANOVA, "To Cut or Not to Cut...Medical Male Circumcision for HIV Prevention: Implications for MSM."

AIDSTAR-One

John Snow, Inc.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: info@aidstar-one.com
Internet: aidstar-one.com

CONTENTS

Acronyms..... v

Executive Summary vii

Day One Presentations I

Day Two Presentations..... II

Day Three Presentations 21

Conclusion..... 23

Appendix I: Summary of Practicum Sessions 25

ACRONYMS

ALCS	Association de lutte contre le SIDA
amfAR	American Foundation for AIDS Research
ART	antiretroviral therapy
CDC	U.S. Centers for Disease Control and Prevention
CEPEHRG	Centre for Popular Education and Human Rights in Ghana
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IMHIPP	Integrated MSM HIV Prevention Program
LGBT	lesbian, gay, bisexual, and transgender
LGBTI	lesbian, gay, bisexual, transgender, and intersex
M&E	monitoring and evaluation
MARP	most-at-risk population
MSM	men who have sex with men
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
VMMC	voluntary medical male circumcision

EXECUTIVE SUMMARY

BACKGROUND

Few populations around the world are more threatened by HIV than men who have sex with men (MSM). Recent studies from low and middle income countries indicate that MSM populations are up to 19 times more vulnerable to HIV than the general population,¹ due in part to unprotected anal intercourse and other high-risk behaviors. The risk is compounded wherever homophobia and criminalization drive MSM underground: social marginalization, stigma, and discrimination tend to both drive riskier behaviors and effectively limit men's access to health services.

For decades, HIV prevention and care programming for MSM in Africa was practically nonexistent. In many cases, policymakers and health leaders knew little about MSM; some actively denied the very existence of MSM within their countries. This was exacerbated by the lack of data about MSM, as little research had been conducted on MSM and their health needs anywhere on the continent. Even basic information was unavailable: the size of MSM populations, how and where they socialize with each other, or what their prevention needs are. Stigmatization throughout African society inhibited the ability of MSM to organize themselves and advocate for their rights and for access to health services, as well as to demand the research necessary to design HIV programming for their communities.

In recent years, however, the situation has been changing rapidly. Important new research initiatives in several African countries have yielded valuable information about MSM and are informing regional-, national-, and local-level HIV policy and programming. While hostility and punitive legal obstacles persist—and may even be growing—in some countries, organizations dedicated to fighting for the health and human rights of MSM and lesbian, gay, bisexual and transgender people are becoming more visible throughout Africa. These developments, supported by the new evidence base and new funding, present extraordinary opportunities to build and extend HIV prevention and care programs for African MSM.

OBJECTIVES

This intensive three-day workshop on HIV programming for MSM in Africa was a historic opportunity for researchers, government officials, program managers, advocates, and donors from throughout Africa and the world to share and discuss the latest evidence-based developments in HIV programming for MSM. A primary goal of the gathering was to review the U.S. President's Emergency Plan for AIDS Relief 2011 [*Technical Guidance on Combination HIV Prevention*](#), which describes the U.S. Government's comprehensive package of core services for MSM as well as U.S. policy promoting human rights and an enabling environment in order to ensure access to health services for MSM.

¹ Baral, S., F. Sifakis, F. Cleghorn, and C. Beyrer. 2007. Elevated Risk for HIV Infection Among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000-2006: A Systematic Review. *PLOS Medicine* 4:1901–1911.

Some 150 participants from 22 African nations, the United States, Europe, and Australia came to Johannesburg to present information on program and research activities in their countries, as well as to learn about recent advances and best practices in HIV prevention technologies and their potential for increasing protection options for MSM. In addition to 40 presentations, two interactive open-mic and eight break-out practicum sessions were opportunities to raise concerns, share program experiences, and advocate for more support.

OVERVIEW OF THE AGENDA

Day One opened with an introduction to the U.S. President's Emergency Plan for AIDS Relief guidance and its implications for MSM programming in Africa, followed by an in-depth look at efforts to strengthen MSM communities throughout Africa. Five sessions totaling 18 presentations focused on a broad array of epidemiological, demographic, structural, human rights, and service delivery issues related to HIV and MSM. Size estimations of MSM populations—notoriously difficult to assess given MSM concerns about stigma and violence and concerns about self-identification and anonymity—and the value of conducting ethnographic research on MSM were discussed. One session examined the structural and contextual issues that organizations providing services or advocating for MSM face in Africa, including punitive legal systems, profound homophobia throughout society, discriminatory clinic practices, and other challenges. Presentations on the epidemiology of HIV transmission among African MSM and the use of viral subtyping to describe the sexual networks of MSM provided key information for planning and evaluating prevention programs for MSM. A fourth session looked at the critical importance of using intervention strategies based on a human rights perspective. The final session of the day addressed stigma and discrimination as barriers to service delivery for MSM and innovative solutions developed in South Africa and Ghana.

Five sessions on Day Two (18 presentations altogether) covered a broad array of topics related to intervention strategies. They first discussed efforts to improve and expand community-based outreach, including the creation of a peer educator manual to improve outreach activities to MSM in Ethiopia. Male and female condoms and lubricants were the focus of four presentations from Kenya, Morocco, and South Africa, covering research and program experience in increasing acceptability, access, and use among MSM. Three speakers then discussed HIV testing and counseling strategies for MSM, including a program in Côte d'Ivoire. Sexually transmitted infection prevention, screening, and treatment as well as access to care and treatment were covered in a fourth session, which included presentations on health interventions for MSM based in Côte d'Ivoire and the United States. The final session of the day was an intensive examination of size estimation methodologies and on monitoring and evaluation. Day Two also included an open-mic session and four break-out practicum sessions on capacity building, security and support, outreach to diverse MSM populations, and using technology to reach MSM.

Day Three's single session of presentations focused on emerging and state-of-the-art prevention interventions and their application for MSM populations, including the iPrEx trial of pre-exposure prophylaxis, rectal microbicides, and voluntary medical male circumcision (VMMC). The day included a second open-mic session and four practicum sessions on capacity building, biological interventions, alcohol and drug use among MSM, and policy analysis and advocacy to promote human rights within HIV interventions for MSM.

The workshop agenda is available at www.aidstar-one.com/sites/default/files/Agenda_FINAL.pdf, and the workshop presentations are available at www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/msm_africa.

CONCLUSIONS

The workshop successfully covered a broad range of issues in research, programming, and advocacy for MSM in Africa facing the threat of HIV. Each of the 40 presentations prompted in-depth discussion and offered an invaluable opportunity to exchange ideas and experiences from all regions of Africa. The sessions also provided an important platform for sharing perspectives across all levels, bringing activists and advocates, program managers, government officials, donors, researchers, and others together.

Several key principles were discussed repeatedly in many sessions and across many topics:

- The importance of new evidence for MSM program planning, including size estimation studies and other methodologies to fill in information gaps on MSM communities
- The continuing need to combat stigma and discrimination, which prevent MSM from seeking health care and from taking a leadership role in society in their own interest
- The imperative of using a human rights framework to build HIV program strategies for MSM, which includes ending legal barriers and outright criminalization of homosexual sex and creating an enabling environment overall
- Creating linkages to care for MSM who test positive for HIV, so that services are available immediately when needed
- Increasing the availability of essential commodities, such as condoms and water-based lubricants
- Using research to adapt emerging prevention interventions for MSM, including new biomedical methods such as pre-exposure prophylaxis, rectal microbicides, female condoms, VMMC, and others.

DAY ONE PRESENTATIONS

Presentations from the workshop are posted at www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/msm_africa. The following are summaries of each presentation from day one.

PEPFAR HIV Prevention, Care, and Treatment Program Strategy for MSM: MSM Guidance, Current Status, and Future Prospects (Richard Needle, Office of the Global AIDS Coordinator, United States)

Moderator Richard Needle opened the three-day workshop with an overview of recent U.S. Government policy statements and documents that have created groundbreaking new opportunities for global HIV programming for men who have sex with men (MSM). In 2011, [the U.S. President's Emergency Plan for AIDS Relief \(PEPFAR\) released guidance](#) on a core package of services for MSM based on evidence and built on human rights principles and sound public health practice. The guidance follows the 2008 legislative reauthorization for PEPFAR and the Office of the Global AIDS Coordinator, which made a clear commitment to developing HIV programming for MSM. A [memorandum issued on November 6, 2011](#), by President Obama, released on the same day that Secretary of State Hillary Clinton gave a [compelling speech](#) on achieving an AIDS-free generation, further reinforces these new policy perspectives on most-at-risk populations, including MSM. The memorandum directs all agencies of the U.S. Government to ensure that U.S. diplomacy and foreign assistance promote and protect the rights of lesbian, gay, bisexual, and transgender (LGBT) persons. With the support of country governments, backed up by enforcement that combats criminalization and violations of human civil rights, this commitment will go a long way in accelerating progress. The guidance also states the U.S. Government position that all new scientific advances—such as treatment as prevention—benefit all populations equally. This workshop's objective was to inform global partners and stakeholders on the guidance and to begin a broad-based, bidirectional discussion on implementation to ensure effective prevention, care, and treatment programming for MSM. Language for the reauthorization bill for 2013 is currently being discussed, with the hope that it will be even stronger than the current guidance document. These strong and growing commitments on the part of the U.S. Government and participating countries, combined with the advocacy of civil society and dedication to promoting human rights, will lead to success in scaling up access to services for MSM.

Community Strengthening in Hostile Environments: What Can We Learn from Recent Experiences in Africa? (Cheikh Traoré, United Nations Development Programme, United States)

This presentation examines the strategy of community strengthening as a tool for building the capacity of MSM to demand appropriate and effective HIV programming and policies, and to participate in their design and implementation. Community action and advocacy as a response to HIV began in San Francisco in the 1980s, when the gay community mobilized to educate and protect itself from the emerging epidemic even before public health campaigns began, leading to a sharp decline in new infections. Primary mechanisms that communities can use include diffusing knowledge about health, psychosocial processes such as social support and self-efficacy, and access

to local services. Social capital is a multilayered process that helps communities to bond and support each other, even across borders. As people link together into communities, they start demanding a response to and accountability for their needs, including health services and funding. Also critical is the issue of hostility to MSM, particularly in the legal realm. Most countries in Africa criminalize homosexual sex, which has a negative impact not only on MSM but on HIV prevention overall. Other structural factors—culture, religion, gender norms, and policy—also contribute to homophobia and denial of civil and human rights to sexual minorities. Studies have shown that depriving MSM of these rights increases their vulnerability to HIV, pushing them to take riskier behaviors and depriving them of income and health services. For example, criminalization in Senegal creates negative public opinion—exacerbated by the media—about MSM, leading to fear and “closeting,” which keeps MSM from seeking HIV prevention, care, and treatment services, a significant setback for the country’s public health efforts. Indeed, HIV is not always the first priority for MSM populations; stigma, abuse, discrimination, and oppression may take precedence. The answer is a holistic approach that includes public health, human rights, and personal and group development; includes capacity building for MSM and their allies; and emphasizes community strengthening.

Session: Current Epidemiology, Ethnography, and Population Size Estimation Among MSM in Africa (Moderator: Gaston Djomand, U.S. Centers for Disease Control and Prevention [CDC], United States)

Epidemiology of HIV Epidemics Among MSM: Focus on Africa (Patrick Sullivan, Emory University, United States)

Around the world, many lower- and middle-income countries are experiencing ongoing epidemics among MSM, while newly identified epidemics have emerged in previously unstudied areas, and HIV is concentrated and even resurgent among MSM in high-income countries. Globally, we see inadequate responses, access, uptake, and coverage; the “toolkit” of prevention services tailored for MSM is also inadequate. Although there have been multiple advances in LGBT rights awareness, community empowerment, and activism, all these advances are countered by major pushbacks from institutional powers. There are different patterns of epidemic scenarios, depending on the balance between epidemics as they occur among MSM and the heterosexual epidemic within the larger population. In generalized epidemic settings in Eastern and Southern Africa, the prevailing scenario is where HIV transmission among MSM occurs within a mature and widespread HIV epidemic among heterosexuals. What drives high prevalence among MSM is that the probability of infection per act of unprotected anal intercourse is higher by an aggregate of 1.4 percent than for unprotected vaginal sex. Based on recent data available from across Africa, there are substantial HIV epidemics among MSM, who have an overall estimated HIV prevalence of 18 percent. Data on African MSM are of limited scope—for example, data from convenience samples—and not generalizable to other MSM communities. HIV incidence among MSM is available for a limited number of countries, including Kenya and South Africa; these show an overall incidence at 8 to 10 percent, which is very high. HIV-1 subtypes among African MSM generally have changed over time to reflect the subtypes that circulate more broadly within countries, with a slight overrepresentation of subtype B. Earlier in the pandemic, there was greater differentiation of subtypes between MSM and the general population; this change reveals that MSM epidemics are becoming more like the epidemic within the general population. Individual factors such as unprotected anal intercourse, sexually transmitted infections (STIs), or frequency of sexual partners are important individual-level determinants, but we need to think more broadly about community-level issues, such as access to HIV counseling and

testing and treatment, stigma and discrimination, and such national-level determinants as criminalization.

What Numbers Don't Tell: Defining MSM in Africa Using Ethnography (Vasu Reddy, Human Sciences Research Council, South Africa, and Theo Sandfort, Columbia University, United States)

This presentation encourages the use of ethnographic techniques to understand the sexual practices of MSM as a basis for designing effective HIV prevention programming for MSM. While quantitative questions about MSM behavior can be answered epidemiologically, other key information about the experience of MSM is only available in a qualitative or ethnographic form. Ethnography is a social science that focuses on knowledge and systems of meaning that guide people and their practices, including sexual behaviors. Ethnographic techniques can help explain the diversity in expression and organization of homosexuality, the reasons for risk taking, and the specific same-sex practices that raise risk. Ethnographic methods include descriptive observations, interviews, taking life histories, focus groups, field notes, and mapping exercises. These can elucidate traditional and multilayered cultural and gender norms, violence, unprotected anal intercourse, frequency and number of sexual partners, substance abuse, homophobia, denial and stigma, risk taking, and myths and misconceptions about risk. Ethnography can help us discern the diversity of MSM as well as discover how MSM see themselves. The answers that derive from ethnographic efforts can also help us understand stakeholders and their needs; heteronormativity, relative stigma, and prejudice; the role of such structural realities as economics, gender norms, and poverty; sexual practices; and health care service provision. Ethnographic methods can also be used to evaluate the effectiveness of current prevention initiatives, as well as understand labels and classifications.

MSM Population Size Estimation in Africa (Abu S. Abdul-Quader, CDC, United States)

Estimating the size of MSM populations is critical to informing policy and programs and is feasible in sub-Saharan Africa using an array of methods. Size estimation is one component of monitoring and evaluation, and helps identify the size of the population of concern and the scope of the problem. Estimates serve as denominators for measures of program reach and coverage; they can help with assessment of behavioral risk factors, HIV prevalence, and resource needs to plan an appropriate response with sufficient coverage. Estimates can also be used to project the likely course of the epidemic. Methods include census and enumeration, capture and recapture, multiplier, wisdom of the crowd, network scale-up, and adding questions to existing surveys. Choosing a size estimation methodology requires considering the strengths and weaknesses of each method, which include underlying assumptions, logistical advantages and constraints, and potential biases in measuring and their impact on the population size estimation. Three regional size estimation capacity-building workshops involving 23 countries have taken place in sub-Saharan Africa. Six countries have completed size estimation among MSM, while seven more plan to conduct size estimation within the next year. MSM population size estimation exercises have been conducted for the city of Nairobi, Kenya, including desk review, service multiplier, and wisdom of the crowd methodologies, leading to MSM population size estimates. Size estimation exercises in Angola, Côte d'Ivoire, Ghana, and Mozambique used different combinations of methods.

Session: Background and Challenges (Structural and Contextual Issues) in Addressing HIV Among MSM (Moderator: Billy Pick, U.S. Agency for International Development [USAID], United States)

Achieving an AIDS-Free Generation for Gay Men and Other MSM: Financing and Implementation of HIV Programs Targeting MSM (Owen Ryan, The American Foundation for AIDS Research [amfAR], United States, presented by Kent Klindera, amfAR, United States)

The presentation reports on an amfAR/Johns Hopkins study of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and PEPFAR for HIV programs for MSM in eight countries: China, Ethiopia, Guyana, India, Mozambique, Nigeria, Ukraine, and Vietnam. The study sought to quantify funding amounts between 2006 and 2010, evaluate implementation of the funds on the country level, and examine punitive policies in these countries and how they affect dispensation of funds. A major study finding is that the countries that criminalize same-sex sexual practices—including the three African nations in the study—spend fewer resources on HIV-related health services for MSM and do less to track and study the epidemic among MSM in their nations. These countries are also more likely to redirect donor funds intended for MSM programming; in Guyana, for example, funding amounts for MSM dropped 96 percent between the time the country made its original GFATM request and the finalization of the budget. Another finding is that, despite a rise of 52 percent overall in PEPFAR funding for six of the eight countries between 2007 and 2009, amounts slated for MSM programming did not keep up proportionately. These study results reveal that in many places MSM programming remains a low priority despite the high disease burden these men experience. Inadequate epidemiological surveillance, criminalization of same-sex sexual practices that drives MSM away from health services, stigma and discrimination, and poor understanding of the effectiveness of HIV prevention programs for MSM lead to an ad hoc approach to program development and serious gaps in service delivery.

Challenges in Addressing HIV in MSM Communities in Africa (Joel Nana, African Men for Sexual Health and Rights, South Africa)

Across Africa, cultural and social norms against same-sex sexual practices are a profound barrier to advancing the human rights and right to health of MSM. Widespread misconceptions flourish because of the absence of public education, not only among the general population but among MSM themselves, many of whom remain dangerously unaware of the risk they face. A hostile legal environment—38 African countries criminalize same-sex sexual activity and some are considering even more punitive laws—as well as sensationalist media further fuel homophobia. Despite their high vulnerability to HIV, African MSM were bypassed by HIV interventions until about eight years ago, so there are few available resources such as prevention materials or counseling and testing protocols. While scattered community-based MSM organizations exist, there is limited funding for them, due in large part to social and political marginalization. One successful example is African Men for Sexual Health and Rights, a regional network of 14 MSM/LGBT groups in 13 African countries. African Men for Sexual Health and Rights seeks to strengthen the capacity of national agencies and individuals to improve policy, legislation, and programming for MSM sexual and reproductive health, and increase the visibility of MSM issues through advocacy and support for public health research. The organization facilitates cross-country exchanges, training for capacity building, policy development, and regional advocacy. African Men for Sexual Health and Rights demonstrates the feasibility of building and sustaining community-based MSM efforts in Africa despite multiple barriers.

Côte d’Ivoire: Background and Challenges in Addressing HIV Among MSM (Marguerite Thiam, Ministry of Health and HIV, Côte d’Ivoire)

National HIV prevalence in Côte d’Ivoire is 3.4 percent, while the estimated HIV prevalence among Ivoirian MSM is 24.5 percent. Services for MSM have been available in Abidjan since 2004; the National Program for Highly Vulnerable Populations began in 2008. The country’s National HIV Strategic Plan (2011–2015) includes specific strategies for most-at-risk populations (MARPs), such as a minimum package of services for MSM. The plan seeks to increase services for MSM, improve prevention interventions for HIV and other STIs, build community capacity to respond to HIV, decrease violence against MSM, and reduce their vulnerability overall, with the goal of lowering risk behaviors by 70 percent among MSM. Other recent initiatives include the proposal of a law to protect people living with HIV and creation of a community pool of trainers to combat stigma and discrimination and promote prevention for positives. MSM prevention, care, and treatment services are provided by government in partnership with PEPFAR (through FHI 360), GFATM, and Sidaction. The Ministry of HIV/AIDS works with the CDC to conduct surveillance and biobehavioral research on MSM. Challenges include strong social stigma, inadequate legal protection, the absence of services for MSM outside of the biggest cities, the need for more and better data to base program decisions on evidence, and insufficient community involvement. Program goals include completing a behavioral surveillance survey for MSM, conducting a situation analysis to address MSM issues, using advocacy to improve the legal environment for MSM, and establishing more MSM-friendly drop-in health centers.

Building a Lesbian, Gay, Bisexual, Transgender, and Intersex Movement in Namibia: From Advocacy to Service Provision (Friedel Dausab, Out- Right, Namibia)

The Rainbow Project, the first lesbian, gay, bisexual, transgender, and intersex (LGBTI) rights organization in Namibia, began in 1997 after government leaders attacked LGBTI persons. When it closed in 2009, new organizations, including LGBTI Namibia and Out-Right Namibia, were established to defend the rights of LGBTI citizens. But concerns about the sustainability of new groups such as these include a lack of financial management skills, high operating costs, and dependence on external donor funding that will likely dwindle over time. Working with the Namibian government, Out-Right Namibia signed a “hosting agreement” (ending at the end of 2012) with an established nongovernmental organization (NGO), Positive Vibes, to allow it to build the capacity to develop effective and efficient financial management and oversight and become sustainable. An important activity is advocacy around a new “AIDS law” that is in the process of being drafted, as well as reform of Namibia’s 1927 Sodomy Law. Other rights-related activities include a short-term project to launch a documentation process focusing on human rights violations against LGBTI. There is currently no funding available to provide a targeted continuum of care for MSM/LGBTI, which would include counseling, support for “coming out,” and dealing with violence and substance abuse. Clients who identify themselves as LGBTI at public health care facilities risk stigma and discrimination from facility staff, a problem that needs to become a focus of advocacy efforts. Research to determine HIV prevalence and risk factors for MSM has been done on a very small scale; a study funded by the CDC and led by the Ministry of Health and Social Services and a size estimation of the MSM population are under way.

Session: Implementation of Comprehensive Packaged of Integrated Evidence-Based HIV Prevention Services for MSM (Moderator: Carlos Toledo, CDC, South Africa)

MSM-HIV Epidemic in Africa: An Integrated Response to Diverse Epidemics (James McIntyre, ANOVA, South Africa)

This presentation explores the diversity of individuals who are labeled “MSM” in Africa and how that diversity—in behavior and in self-identification—must be understood to effectively address HIV within these populations. No single message or prevention strategy will reach all MSM/LGBT. There are hidden African MSM populations who do not identify with “gay culture” and who are unaware of their HIV risk because of poor HIV education and few MSM-targeted prevention programs. Many African MSM, especially those living in countries where homosexual sex is criminalized, also have sex with women. Transgender people have specific programming needs. For MSM, having unprotected anal intercourse is common and is a primary risk factor for HIV. Existing prevention services are inadequate to serve MSM communities if individuals avoid them because of homophobia, violence, and stigmatizing attitudes, especially among health care providers. Integrated services—structural, behavioral, and biomedical—are needed to provide a comprehensive and holistic approach to meeting the HIV prevention needs of MSM. Combination prevention can enable men to choose among strategies that work for them. Although promising new biomedical prevention interventions are emerging, no single approach will control the spread of HIV, and combining intervention strategies may have synergistic impacts on incidence. We must recognize that there is a false divide between the biomedical and the behavioral realms, as implementing successful biomedical interventions allows programs to refocus on behavior modification. Challenges to providing MSM-friendly health services include reaching hidden MSM who do not self-identify as gay, combating stigma and discrimination, and overcoming real and perceived barriers to testing and treatment. The Health4Men sex-positive model of prevention recognizes the need for gay-friendly, context-relevant, and respectful messaging that normalizes and celebrates male-to-male sexuality. Unprotected anal intercourse should be the focus of prevention messaging campaign, and biomedical prevention strategies—such as early treatment and treatment as prevention—need to be expanded for MSM. Efforts to address stigma by integrating the MSM prevention package within the general prevention package are optimal, as is use of social media, the Internet, and other technologies, such as cell phones and text messages.

The MSM Epidemic 2012: What Prevention? (Linda-Gail Bekker, Desmond Tutu HIV Centre, University of Cape Town, South Africa)

This wide-ranging presentation discusses biomedical HIV prevention developments and their potential for HIV prevention programming for MSM; these include male circumcision, rectal microbicides, treatment as prevention, female condoms for anal sex, vaccines, and early antiretroviral treatment. Creating targeted prevention packages for MARPs has become a priority, but more research is needed to determine the best components of that package for MSM. Current and upcoming biomedical and behavioral trials for MSM are scheduled in the United States, Peru, Thailand, and South Africa. Condoms remain an important prevention tool, but their strength varies under different usage conditions, affecting safety and effectiveness. Recent research on lubricants has revealed that certain brands significantly enhance HIV-1 transmission. More research is also needed on STIs and HIV vulnerability in MSM. The iPrEx trials showed that oral pre-exposure prophylaxis provides additional protection against HIV for MSM receiving a comprehensive package of prevention services. The ADAPT study is one of several that is continuing research on pre-exposure prophylaxis for MSM. The HIV Prevention Trial Network 052 trial, which showed a 96

percent reduction in HIV transmission in discordant couples when the HIV-infected partner began antiretroviral therapy (ART) early, included only 37 MSM couples, for whom similarly effective results were shown. While many believe that ART will also reduce penile-anal HIV transmission, more research is needed to confirm this. With progress made on the microbicide front in the past few years, demand is growing for a rectal microbicide. The RMP-01 study of a gel formulation is in phase 1; three rectal studies of tenofovir are ongoing. Other current research with potentially important implications for MSM includes a study of circulating HIV clades among MSM in Cape Town, South Africa. The results also reveal the different networks in which different racial groups circulate and the extent of “bridging” between the generalized heterosexual epidemic and the concentrated epidemic among MSM.

Session: Enabling Environments: A Human Rights Approach to HIV Prevention Among MSM (Moderator: Kent Klindera, amfAR, United States)

Key Global Policy Frameworks for MSM and HIV Funding and Programming (Don Baxter, Global Forum on MSM & HIV, Australia)

The Global Forum on MSM & HIV aims to ensure equitable access to HIV programs, services, and resources for MSM by working to influence global policies and resource allocation. The presentation highlights six important policy initiatives that represent progress in recognizing the need to address the HIV-related needs of MARPs and MSM. The UN Political Declaration on HIV and AIDS (June 2011), signed by all countries in Africa, requires governments to create programs targeted to MSM. The Global Fund Sexual Orientation and Gender Identity Strategy increases pressure on African governments to include MSM in their national HIV strategies. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization strategies (2011) provide guidelines for prevention and treatment of HIV and other STIs among MSM and transgender people. The Strategic Investment Framework spells out necessary components for a successful national response to support MSM programs. Finally, the new Global Commission on HIV and the Law convenes jurists and political lawyers to discuss and issue recommendations on repeal of laws that impede HIV programs and on enactment of protective legislation. All of these policy frameworks have been aligned, and their implementation portends the possibility of ending AIDS. The presenter recommends actively engaging with local MSM organizations but also recognizing that decriminalization may not be as high a priority for them as equal access to services and programs.

MSM, Public Health, Human Rights, and the Dilemma of HIV/AIDS Policy (Gift Trapence, Centre for the Development of People, Malawi)

Estimated HIV prevalence in Malawi is 10.6 percent among adults 15 to 49 years old; over 900,000 people in Malawi are living with HIV. Among 200 MSM tested for HIV in a study in Blantyre, prevalence is 21.4 percent; 95.3 percent of these men had been unaware of their HIV status. The National HIV Prevention Strategy (2009–2013) proposes interventions that target prevention messages to MSM and improve access to HIV services. Currently, a population size estimate and a Combined HIV Prevention Intervention are taking place. On the program front, PEPFAR (through PSI and PACT) is supporting HIV peer education interventions that have reached more than 400 MSM. Although the 2003 Malawi national HIV policy acknowledges same-sex relationships and includes protection of human rights as a priority, the legal and regulatory framework to reduce the vulnerability or protect the human rights of MSM and other MARPs is not yet in place, and the extent of government commitment is not clear. Some public leaders take the position that there are too few MSM in Malawi to be a significant factor in the epidemic, while others promote

homophobic attitudes and support continuing the criminal status of same-sex relationships. There is widespread stigma and discrimination throughout public life, although media training on MSM has improved reporting. Results from the two research efforts should provide the evidence needed to justify prevention programming for MSM and help break the silence on MSM within the larger population. PEPFAR programs can help by addressing structural barriers, including legal and human rights issues that make it difficult for MSM to access health services. PEPFAR should also help build the capacity of Malawian agencies and institutions to carry out work on an HIV response for MSM, as well as work to strengthen the government's commitment to respond to the needs of MSM.

HIV Prevention, Care, and Treatment for MSM: A Review of Evidence-Based Findings and Best Practices (Lundu Mazoka, Friends of RAINKA Medical Consultancy, Zambia)

In most of Africa, a punitive legal environment and homophobic social, cultural, and religious attitudes continue to impede progress on developing HIV prevention programs for MSM. Yet even in nations with repressive laws, it is possible to move forward if the political will is present, given the growing body of knowledge about MSM as well as new policy guidelines that provide direction. For example, in Lesotho, prisons have started to distribute condoms to inmates despite anti-sodomy laws. Despite structural and legal barriers, those working to launch services for MSM should not wait for a green light from the authorities to get started by first making existing services accessible to MSM and other MARPs, and by ensuring that they are delivered without stigma and discrimination. The speaker urges advocates and those working in prevention to promote correct and consistent condom use with appropriate lubricants.

From Silence to Response: A Rights-Based Approach for MSM Interventions (Mmapaseka “Steve” Letsike, Health4Men, South Africa)

The PEPFAR-funded Health4Men, founded in 2009 in response to South Africa's National Strategic Plan, was Africa's first public-sector clinic dedicated to MSM. Four Health4Men sites provide community-based outreach programs; develop and share expertise and technical support to the Department of Health on MSM, sexuality, and gender issues affecting prevention, treatment, and support; and conduct both biomedical and psychosocial research. Human rights are the platform upon which Health4Men and similar groups build their activities. For improving public health, attention to human rights can maximize coverage, scale, uptake, impact, and quality, as well as increase the involvement of MARPs and people living with HIV. The program's focus on MSM helps reach a marginalized group that greatly needs but has historically had little access to services; has very high HIV prevalence locally—greater than 33 percent (2010)—and internationally, as well as high levels of other STIs; and has sex with women as well as men, which suggests “bridging” between most-at-risk MSM and the general population.

Session: Intervention Strategies: Addressing Stigma and Discrimination to Improve Service Delivery (Moderator: Marina Rifkin, CDC, South Africa)

MSM Sensitivity Training for Health Workers in South Africa (Linda-Gail Bekker, Desmond Tutu HIV Foundation, South Africa)

Three separate studies (2008, 2009, 2011) have documented discriminatory treatment of MSM in South African health facilities. Research in Cape Town found that MSM have a variety of opinions about different sources of health care. Private health care is very expensive and difficult to access but is believed to offer better confidentiality, while public sector health care is criticized for the high levels of stigmatizing and abusive behavior by staff, for poor confidentiality, and for lack of MSM-

specific medical knowledge. MSM-specific services are seen as open and supportive, but they are available only in a limited number of cities and communities. To improve treatment of MSM at health clinics, an MSM sensitivity training manual for health workers, supported by the International AIDS Vaccine Initiative and PEPFAR, has the potential to improve uptake of services by MSM at minimal cost. Assessment of the manual shows that those who use it experience an overall shift in their attitudes toward MSM and a greater willingness to accept the personal sexual choices of individuals. These changes in attitudes improve the ability to provide services and attract MSM clients. The MSM community and public health clinic staff appear to show commitment, but long-term follow-up, monitoring, and evaluation are necessary for scale-up. The government also needs to buy in to the training so it can establish national training guidelines and extend the training to the police and justice services.

MARP Friends and MARP Watchers: A Community-Based Rapid Response and Protection System for Key Populations (Jacob Agudze Larbi, FHI 360, Ghana)

The Ghana AIDS Commission is currently implementing the country's Third National Strategic Plan (2010–2015), which includes new strategies for prevention and care programming for MARPs and for creating an enabling and safer environment. The Strengthening HIV/AIDS Partnership with Evidence-Based Results Project, funded by USAID/PEPFAR, seeks to improve the knowledge, attitudes, and practice of key health behaviors among MARPs and people living with HIV, expand use of HIV counseling and testing and of STI screening, and strengthen the capacity of program implementers. The Strengthening HIV/AIDS Partnership with Evidence-Based Results Project's services include peer education, condom and lubricant promotion and sales, drop-in centers, cell phone and text messaging reminder systems, a referral network, violence response services, and more. One innovative program component is M-Friends and M-Watchers, a protection network integrated into community-based HIV prevention and care activities. Supported through FHI 360 and implemented through 33 partners, the network includes a female lawyers association, gender specialists, peer educators, and a national MARPs technical working group. Network lawyers and other members are trained to respond to incidents of violence, discrimination, and abuse of legal rights. By prosecuting violent offenses (including murder and rape), facilitating medical care, and advocating for police protection for MSM and sex workers, the network's support activities have created a greater sense of security among MARPs and implementing partners. Challenges include dealing with a persistently hostile environment for MSM, negotiating a complex legal system, expanding the role of the police in the network, and creating linkages with other human rights and legal associations not currently working with MARPs.

DAY TWO PRESENTATIONS

Presentations from the workshop are posted at www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/msm_africa. The following are summaries of each presentation from day two.

*Session: Intervention Strategies: Community-Based Outreach Programs for MSM
(Moderator: Cameron Wolf, USAID, United States)*

Reaching MSM: Key Issues and Strategies for Community-Based Outreach (Kent Klindera, amfAR, United States)

The amfAR MSM Initiative is a small grants and capacity-building/mentoring program that conducts community-led research and advocacy, and operates on a regional, peer-led decision-making process. The Initiative's objectives are to address the basic needs of MSM, including employment, family and intimate relationships, and stigma and discrimination; create a safe space for MSM to meet; and offer integrated health and wellness services. More than 117 organizations in 66 countries around the globe serving MSM have received grants. One grantee is Alternatives Cameroon in Douala, whose comprehensive wellness program includes a primary health care clinic, HIV testing and counseling, bar-based and online outreach activities, and legal support, as well as policy advocacy. Another grantee, the Centre for Popular Education and Human Rights in Ghana (CEPEHRG), conducts outreach on the street and in bars, sponsors an integrated behavior change campaign, and sponsors a theater-based stigma reduction campaign. In Mombasa, Kenya, the community-based organization Persons Marginalized and Aggrieved engages Christian and Muslim religious leaders to change public attitudes about MSM, works with health care workers to make services more MSM-friendly, supports family reintegration, and provides a safe space where MSM can meet. For donors and stakeholders, amfAR recommends investing in MSM programming for the long-term, working to remove legal barriers and end harassment against MSM, initiating poverty reduction activities, conducting behavior change communication and advocacy, and measuring the impact of activities.

Improving Community Outreach and Access to Commodities and Services through the Development of an MSM-Specific Peer Educator Manual in Ethiopia (Dereje Teferi, Rainbow-Ethiopia Initiative for MSM, Ethiopia)

Adult HIV prevalence in Ethiopia is an estimated 2.4 percent (2010), a total of about 1.2 million people living with HIV, one of the largest HIV-positive populations in the world. Although data about MSM or other MARPs in Ethiopia are lacking, high-risk sexual practices within this population are common, so it is likely that Ethiopian MSM—like MSM in neighboring countries—are disproportionately affected by HIV. The Rainbow-Ethiopia Initiative for MSM takes an integrated, holistic, peer-based approach to programming for sexual health and psychosocial well-being among MSM. Target MSM populations include youth, male sex workers, and married men. A primary goal is to reduce stigma and discrimination in the society at large and to advocate for the right of MSM to good health and access to comprehensive care and treatment. The organization has developed the first MSM training manual for Ethiopia with EngenderHealth, USAID, and amfAR,

as well as behavior change communication materials for MSM within the Ethiopian context. Services include psychosocial counseling and support in safe spaces to build self-worth, referrals to MSM-friendly HIV counseling and testing and STI services, promotion and distribution of male and female condoms and lubricant, wellness workshops and post-test clubs, community mobilization, online forums to disseminate sexual health education, and cooperation with researchers to conduct size estimation and behavioral research. Challenges include the criminal status of same-sex sex acts, coupled with widespread stigma and discrimination, which inhibit organizations seeking to create services for MSM; the government's lack of engagement in tracking, planning for, or providing services to MSM; inability to register as an official NGO; and severe scarcity of water-based lubricants throughout the country.

Ghana: Intervention Strategies: Community-Based Outreach Program for MSM (Mac-Darling Cobbinah, CEPEHRG, Ghana)

In Ghana, CEPEHRG's mission is to "improve and expand the provision of human rights and HIV/AIDS services for young people and sexual minorities through information, education and empowerment." CEPEHRG serves multiple segments of the LGBT population, including older MSM, MSM sex workers, and young MSM, as well as people living with HIV. CEPEHRG conducts community outreach to promote and distribute condoms and lubricants, and encourages MSM to get counseling and testing, and to be tested and treated for STIs, services available at the organization's center. CEPEHRG also refers clients to MSM-friendly centers for viral load testing, ART, and STI treatment, and links MSM with HIV infection to the National Association of Persons Living with HIV. The LGBTI Community Center offers support groups for MSM, MSM sex workers, alcoholics, and other groups, as well as theater performances, an Internet facility for research and networking, and a library service. The program has not yet benefited from institutional capacity building, does not yet have a strategy for sustainability, and lacks needed equipment. Other challenges include overcoming the high levels of stigma and discrimination against LGBT, both from society at large and at health centers where staff are hostile to sexual minorities.

Session: Intervention Strategies: Condoms—Innovations for an Old Solution (Moderator: Timothy Mah, USAID, United States)

South Africa: Health4Men, An Innovative Twist in HIV Prevention (David Motswagae, ANOVA, South Africa)

Consistent and correct use of condoms and water-based lubricant remains an important part of HIV prevention efforts. Despite the effectiveness of these prevention tools, cultural, behavioral, and structural barriers to condom use, as well as poor general knowledge about HIV, limit their uptake by MSM. Although the Department of Health distributes free condoms, they are not available everywhere, and water-based lubricant is costly and largely unavailable. Public perception about condom safety plummeted in 2007, when 3 million government-issued Choice condoms were recalled because they were suspected to be defective; a second recall in 2009 of a million condoms of the same brand deepened mistrust. Health4Men developed a sex-positive messaging model emphasizing sexual pleasure and affirming homosexual sex without shame. Health4Men partners with *shebeens* (unlicensed bars) to widen distribution of condoms and lubricant and display posters, coasters, and other forms of media with messaging on condom/lubricant use. These messages focus on responsible sex and on reduction of homophobia and stigma. Innovative responses to needs and concerns expressed by MSM include introducing larger condoms as well as black condoms, and

promoting use of female condoms for anal sex. Posters in shebeens are displayed in frames and are changed regularly.

Kenya: Condom and Lube: Acceptability, Access, and Use (Peter Njane, Ishtar MSM, Kenya)

In Kenya as in many other African countries, homosexuality is taboo and is considered “un-African” and abnormal, even supernatural. Christian and Islamic religious leaders join political leaders in condemning homosexuality and vilifying MSM. MSM are vulnerable to blackmail from the police and are victimized by hate crimes. Within this hostile environment, many young MSM are coerced into heterosexual marriage by their families or communities. Ishtar MSM is a community-based HIV prevention organization that seeks to remedy the negative effects of stigmatization of MSM and expose the role that homophobia plays in raising vulnerability to HIV. Major activities include advocacy on policy development for HIV prevention, peer education, distribution of condoms and lubricants, referrals for MSM health needs, safe sex workshops and open forums, and post-test clubs. Another important issue is sensitization of health care providers to the needs of MSM and abatement of discrimination against MSM in clinic settings. Ishtar MSM launched the Link Project (2010–2011) to create an independent condom and lubricant distribution system for MSM and men who have sex with women in Nairobi. Peer educators handle distribution and lead educational activities. Recommendations include decriminalization of same-sex sexual activity, creation of national policy guidelines on lubricants for MSM, registration of MSM organizations as officially recognized groups, and scale-up of referral systems to MSM-friendly providers.

South Africa: Universal Access to Female Condoms (Tian Johnson, African Alliance for HIV Prevention/SUPPORT Worldwide, South Africa and Kenya)

The history of female condoms in South Africa has not been smooth. Only one World Health Organization–prequalified female condom—the FC2—is available in the country today, after more than six years of difficulties with procurement and other problems. Shortages and stockouts have and continue to be serious barriers to distribution and use of female condoms. Female condom product labels specify vaginal use only; there is as yet no regulatory approval for anal use. But the need for protection during anal sex is clear in South Africa; studies have shown that over a three-month period, 14 percent of male and 10 percent of female STI clinic clients in Cape Town practiced anal sex. Funding is thus critically important for research on the female condom and anal sex, as well as developing guidelines for their use. More support is also needed for lubricant programming within national condom programs, as well as for research and advocacy on rectal microbicides. Project Africa for Rectal Microbicides seeks to involve Africans in rectal microbicide research and advocacy and to ensure the availability of rectal microbicides “to all Africans who need them.” Access to lubricants is also a top priority. A strategy document will be released at the upcoming Microbicides 2012 meeting that discusses African priorities for rectal microbicide research and advocacy.

Rolling Out MSM Programs in Morocco (Othman Mellouk, Association de lutte contre le SIDA [ALCS], Morocco)

With offices in 19 cities across Morocco, ALCS focuses on three primary missions: HIV prevention for all MARPs and migrants, care and support for people living with HIV, and defense of the rights of people living with HIV and MARPs. The overall objective is to ensure access to information so that MSM and other MARPs can take advantage of testing for HIV and STIs, HIV care, and psychosocial support. Inspired by MSM programs in Europe, in 1993 ALCS volunteers sought to

launch activities with a knowledge, attitudes, and behavior survey that revealed that very few MSM in Morocco had basic information about HIV, and that very few were using condoms. In 1998, the first intervention, supported by UNAIDS and the European Union AIDS Task Force, began on a small scale in four cities. As the MSM community began to grow and become more visible, Moroccan society became more conservative, and homophobic violence made it hard to engage with MSM in outdoor cruising areas. As a result, Moroccan MSM turned to the Internet to meet other MSM, so in 2006 ALCS began web-based interventions. In 2010, ALCS opened its first clinic for the reproductive health of MSM in Marrakesh, funded by amFAR, opening the way for broader community-level interventions. Key services include peer education, case management, and one-on-one counseling. ALCS just finished the first integrated biobehavioral surveillance of Moroccan MSM in two cities; for the first time, there are solid data on MSM in Morocco ready for dissemination. Notably, civil society conducted the survey, in partnership with UNAIDS and the Ministry of Health. Challenges include the fact that almost 100 percent of funding comes from foreign sources. The government is currently led by an Islamist administration and is difficult to work with, police harassment has grown, and outreach workers are vulnerable to arrest.

Session: Intervention Strategies: HIV Testing and Counseling (Moderator: A.D. McNaghten, CDC, United States)

Côte d'Ivoire: Targeted HIV Testing and Counseling Services for MSM at the Clinique de Confiance (Timi Kouakou Alain, Espace Confiance, Côte d'Ivoire)

The Clinique de Confiance began in 1992 as a clinic offering confidentiality and privacy for female sex workers and their stable partners in Abidjan. In 2004, clinic staff created the NGO Espace Confiance for MSM, with services and hours targeted to their needs. Services include peer outreach health education, referrals, STI screening, HIV counseling and testing (including rapid testing), promotion of female condoms and lubricant, a mobile clinic, ART, and more. STI/HIV services for MSM include syndromic STI screening with a rectal examination and STI treatment, and referrals for advanced genital infections, such as rectal condyloma, or for advanced STIs. Espace Confiance's staff are trained to understand the health and psychosocial needs of MSM and to respect their rights. Ongoing challenges to expanding MSM services in Côte d'Ivoire include a lack of national reference manuals created with staff participation and guidelines for developing an MSM-friendly clinic environment. MSM services are currently available only in large cities, so scale-up to less urbanized regions is important. Greater community outreach and advocacy are necessary to counter stigma and discrimination, and create an enabling environment to sustain MSM services. To increase resources to support MSM interventions, it is worthwhile to get involved in both national and international networks for MSM programming. The Clinique de Confiance hopes to improve its services by reinforcing the ability of medical staff to treat rectal condyloma, such as equipping the lab for ART biological screening, strengthening medical management for clients, and becoming a national and regional learning center for services for MARPs.

South Africa: Community-Driven HIV Testing and Counseling (Dawie Nel, OUT, South Africa)

Founded in 1996, OUT is involved in a wide range of activities to provide services and other forms of support for MSM, including legal reform, research, training, peer education, and alliance building with other LGBT groups. OUT's clinical services include HIV prevention education and methods (condoms and lubricant), HIV counseling and testing, case monitoring, and post-exposure prophylaxis. Clinic staff include a gay male nurse and peer workers to make clients more

comfortable. Outreach takes the form of peer education, work with the gay press, and cell phone networks. The clinic conducts ongoing assessments of access, convenience, and health surveillance. OUT also conducts HIV testing and counseling at MSM-centered venues and events. After tests are given, clients receive risk reduction interviews and, if needed, referrals. Repeat clients get an individual risk reduction plan that includes drug- and sex-related risks and plans for HIV testing. Among OUT's research efforts was the first quantitative study on empowerment of LGBT people in Gauteng (2003). Other research has examined the self-reported serostatus of MSM of different races, as well as stigma and how it affects risk.

New Approaches to HIV Counseling and Testing (Patrick Sullivan, Emory University, United States)

Because MSM are not a homogeneous group, it is important to develop and test a mix of options to find the right approach for a given MSM population. Testing and retesting are key because, in some places, as many as 95 percent of men do not know they are HIV-positive. In places where HIV incidence among MSM reaches 10 to 15 percent, it is important to retest. Key issues associated with testing include stigma associated with testing (concerns about appearing at clinics for testing), inadequate disclosure of results to partners, and assumptions about the serostatus of a partner. Solutions include couples voluntary counseling and testing, at-home testing, at-home self-testing, and text message reminders for periodic retesting. Couples voluntary counseling and testing, which is supported by the new PEPFAR guidance, tests both members of a couple together and has been shown to reduce HIV transmission in serodiscordant couples. Data from five countries, including South Africa, show high levels of willingness among MSM to use couples voluntary counseling and testing (2011). Many MSM respondents see couples voluntary counseling and testing as a sign of commitment to each other, synonymous with marriage, and believe that getting tested together allows couples to offer emotional support to each other. Another reason given by respondents to get tested as a couple was that it would allow a monogamous couple to stop using condoms. In the United States, a willingness-to-test study of MSM (2009) also showed high levels of willingness to take an at-home HIV test—which requires sending the test kit to a laboratory to get results—whether or not a cash incentive was offered. Overall, 82 percent of study participants sent the completed test to the laboratory to be analyzed. At-home HIV self-testing for MSM—where results are available at home after using a quick test—will be studied soon in a randomized trial to be conducted by the CDC. Research on text reminders for HIV retesting (2011) has shown that they more than double the likelihood that the text recipient will retest within nine months.

Session: Intervention Strategies: Sexually Transmitted Infection Prevention, Screening, and Treatment: Access to Care and Treatment, and Linkage to Care and Evaluation (Moderator: Gaston Djomand, CDC, United States)

Health4Men: An African Model for Working with MSM (Oscar Radebe, ANOVA, South Africa)

Health4Men was one of the first projects in South Africa providing services to meet the sexual health needs of men and MSM. It opened clinics in 2009 in Cape Town, Soweto (also a center of excellence), Khayelitsha, and Pretoria (an outpatient clinic); new clinics have opened since in Soweto and elsewhere, with more planned. The organization also works with the Department of Health to integrate services within existing health centers, using a model that allows MSM to access targeted services and that helps facilities develop expertise in clinical services for MSM. Community-based outreach activities and information, education, and communication materials that use a sex-positive

approach—with messaging that characterizes MSM sexuality as normal and positive—help overcome the sense of shame that many MSM experience due to stigma and encourage them to seek health care in a clinic environment that understands their needs and does not discriminate against them. Outreach activities take place in the townships and often are centered in shebeens, but in recent years Health4Men has expanded its outreach efforts into the gay media and social media, including Facebook. Services offered include HIV and STI prevention, care, and treatment; mental health and psychosocial support (using referrals to outside providers when necessary); counseling and testing, including counseling for same-sex couples; substance abuse programs; voluntary male medical circumcision; support groups; and more. Future plans include integrating HIV testing and counseling into community centers for “one-stop shopping.” Health4Men trains health care providers to offer MSM-friendly services; to build program sustainability, nurses—who predominate within clinic staffs—are a special target for training, including instruction in initiating ART for clients with HIV. Health4Men is negotiating with government health services to develop clinical protocols for MSM. Health4Men’s Ambassador Program enlists MSM who can serve as respected leaders to promote health services within MSM communities.

Côte d’Ivoire: Interventions Targeting MSM (Blaise Kouadio, FHI 360, Côte d’Ivoire)

Adult HIV prevalence in Côte d’Ivoire is 3.4 percent (2010); for MSM, prevalence is 24.5 percent for MSM and 33 percent for sex workers (including MSM). Before MSM-targeted programming began in 2004, levels of stigma and discrimination were very high, making it difficult to locate and reach MSM. The PAPO Program (2004–2010), implemented by FHI 360 with CDC/PEPFAR funding, provided services to sex workers and 700 MSM, including counseling and testing, STI screening and treatment, and ART. Another program targeting MSM is the National Program for Highly Vulnerable Populations, within the National AIDS Program for Highly Vulnerable Populations, launched in 2008. In 2009, the CDC/PEPFAR conducted a formative assessment in Abidjan, with 32 MSM participating. The assessment revealed a wide diversity of groups and types of MSM based on age, interest, sexual self-identity, and more. The National AIDS Program for Highly Vulnerable Populations developed a policy document specifically for MSM and conducts monitoring and evaluation of projects targeting MARPs, including MSM. A CDC/PEPFAR operations research project is conducting a survey of HIV and associated risk factors among MSM, as well as a biological and behavior risk survey, with results expected in 2013. The data that Survey of HIV and Associated Risk Factors Among MSM produces will provide the evidence base for future MSM programming. To improve and expand HIV programming for MSM and reduce HIV prevalence among MSM, it is important to use advocacy to fight stigma and discrimination, to encourage and develop leadership among MSM, and to strengthen MSM organizations within civil society so they can improve their interventions and expand their reach across the country.

Fenway Health: A Model for MSM Health (Rodney VanDerwarker, Fenway Institute, United States)

Founded in 1971, Fenway Health’s mission is to enhance the health of the LGBT community in Boston, Massachusetts, through high-quality health care, education, research, and advocacy. As of 2010, about 70,000 clients had visited the clinic, with more than 1,600 people living with HIV receiving services. Critical services include mental health, violence recovery, help lines, and substance abuse programs. The approach used is interdisciplinary and patient-centered; services are integrated and comprehensive and are conducted within a systems-based approach to quality and safety. Outreach activities include mobile outreach in bars and clubs and public sex environments, and in drop-in centers, as well as community forums for MSM, transgender people, and African-

American MSM. Fenway Health takes a “bundled approach” to prevention that includes social marketing, peer education, and health navigation/case management, which includes referrals. Since 1984, Fenway has conducted pioneering research on LGBT and HIV/STIs, including treatment, prevention, vaccines, pre- and post-exposure prophylaxis, and rectal microbicides. The LGBT Population Research Center supports a faculty of LGBT population scientists from across the United States and builds archives of population data sets as it conducts training and mentoring. Important lessons learned include the value of direct client participation through Fenway’s Community Advisory Board, whose 14 members represent different sexual and gender minorities as well as communities of color.

Session: Intervention Strategies: Strategic Information and Size Estimation (Moderator: Abu S. Abdul-Quader, CDC, United States)

Uganda: HIV Infection Among MSM in Kampala (Wolfgang Hladik, CDC, Uganda)

Adult HIV prevalence in Kampala (population: 1.4 million) is 8.5 percent; adult male HIV prevalence is 4.5 percent (2004–2005). A survey (2008–2009) conducted by Makerere University, the Ministry of Health, and the CDC sampled six key MARPs using a respondent-driven sampling of MSM 18 and older; participants were all residents of greater Kampala and had to report anal sex with a man in the last three months. Among the sample of 303 MSM—half of whom were younger than 25 years old—data were collected via audio computer-assisted self-interviews focusing on risky behaviors. Respondents were tested for chlamydia, gonorrhea, HIV, and syphilis. More than three-quarters—78 percent—had ever had sex with women; 31 percent either were or had been married, and 29 percent were or had been fathers. Biomarker testing revealed that 22.1 percent had an STI (including HIV); fewer than 2 percent had rectal or urethral gonorrhea, or rectal or urethral chlamydia; 8.3 percent had syphilis; and 13.7 percent were infected with HIV (three times the rate of infection among men in Kampala generally). Men over the age of 25 were substantially more likely to be HIV-positive than younger men (22.4 percent versus 3.9 percent). Within their lifetimes, 26 percent of all respondents had ever been forced to have sex, whereas 37 percent had been blackmailed and 37 percent had been subject to homophobic abuse. One conclusion is that MSM reporting homophobic abuse were five times more likely to be infected with HIV than men who had not been abused. Within the previous three months, 43 percent had had more than 10 sex partners (median: 12) and 42 percent had ever sold sex. More than a quarter (26 percent) never use condoms; condom use overall is suboptimal, ranging between 33 and 50 percent, depending on partner type. Overall, the results show poor knowledge of HIV status, high levels of HIV risk with anal sex, suboptimal condom use, a high number of sex partners, and frequent commercial sex. Recommendations include incorporating MSM into Uganda’s national strategic AIDS strategy and into gender-based violence initiatives, as well as working with the government and civil society to create tailored interventions for MSM. One lesson learned for the research process was that during the 11 months the survey was conducted, sampling slumps occurred twice during periods of crackdowns on LGBT activists and alleged abuse of the LGBT community by police.

Mozambique: MSM Size Estimation Procedures and Lessons Learned (Tim Lane, University of California at San Francisco, United States, presented by Marcos Benedetti, Pathfinder International, Mozambique)

The Mozambique Men’s Study integrated biological and behavioral surveillance survey was undertaken in three cities with the following objectives: to estimate the population size and distribution of MSM; to measure HIV and syphilis prevalence among MSM; to assess the use of and

access to health and social welfare programs among MSM, and identify ways to increase their coverage and uptake; and to enhance local capacity to conduct behavioral surveys, mapping, and size estimation among MSM in Mozambique. Several different methods were used to estimate MSM population size, including wisdom of the crowd, unique object multiplier, unique event multiplier, and service multiplier. Each method has its strengths and weaknesses. For example, some respondents were confused by questions used in the wisdom of the crowd methodology and may have answered incorrectly. The unique event multiplier method can be a fun way to gather the community but can be challenging logistically. These size estimation activities can become good opportunities to provide information on prevention and to distribute condoms and lubricants. Results are expected by August of 2013.

Ghana: MSM Population Size Estimation: Successes and Challenges (Silas Quaye, Ghana AIDS Commission, Ghana)

Conducted alongside an integrated biological and behavioral surveillance, the recent MSM population size estimation exercise in Ghana involved several different methods: desk review, service multiplier, unique object multiplier, wisdom of the crowd, mapping, respondent-driven sampling, and enumeration. The desk review examined data from neighboring countries in West Africa and from other regions in Africa, as well as within Ghana, giving the researchers a starting point. Conducting the service multiplier exercise was difficult; there are few services for MSM in Ghana, and those that collect data did not necessarily have the data content and form to match the needs of the size estimation. A lesson learned is making sure that the questions for the survey are in sync with the service data. The unique object multiplier exercise, during which beads and bracelets were distributed, was very popular and good for recall, but it is important to be able to distribute the object widely across geographic networks. Using the wisdom of the crowd exercise, the researchers encountered similar problems to those described previously for Mozambique, where MSM respondents confused personal MSM network size with their estimate of the number of MSM living in their city. Thus, it is important that staff be well trained and know how to ask follow-up questions that will clear up any confusion. Finally, data from all respondent-driven sampling and non-respondent-driven sampling (mapping only) sites were analyzed to establish median MSM prevalence, which will then be applied to the rest of Ghana. The conclusion is that while it is very possible and indeed useful to conduct size estimation exercises for MSM populations, it is imperative to prepare intensively in advance, particularly if the exercises are conducted in conjunction with an integrated biological and behavioral surveillance or require using service data.

UNAIDS Operational Guidelines for Monitoring and Evaluation of HIV Program for Sex Workers, Men Who Have Sex with Men, and Transgender People (Sharon Weir, MEASURE Evaluation, United States)

When a community randomized trial of the impact of MSM interventions is not affordable or feasible, monitoring and evaluation (M&E) remain important sources of information. UNAIDS, other UN agencies, and other organizations developed a 300-page set of guidelines supporting M&E for networks and organizations of MSM and transgender people, service delivery providers, surveillance units, donors, and NGOs and other civil society organizations. The guidelines can be used to conduct M&E on the national or subnational levels, or at the service delivery level. They provide guidance on how to learn about different routes of HIV transmission, and how to monitor and evaluate the effectiveness of different prevention interventions. Working at the subnational level is especially important because MARPs are not evenly distributed geographically but are often found in clusters. The guidelines recommend the following steps to achieve impact: know your epidemic,

understand your determinants, define what your response or package will be, and determine the inputs you need and how you will assess quality, outcome, and impact. For each of these, the documents include tools and products to show how to use the data. The document also includes guidance on developing an operational definition of the population being studied, as well as guidelines for mapping programs, measuring indicators, and creating and analyzing questions and protocols for surveys.

Tanzania: Outreach in Diverse Settings with Different Kinds of MSM Populations (Shaaban Hassan Haji, Zanzibar AIDS Control Program, Tanzania)

HIV prevalence on the Tanzanian mainland is 5.6 percent; on the two main islands of Zanzibar, adult prevalence within the general population is less than 1 percent, with HIV concentrated among MSM, sex workers, and people who inject drugs. The legal, policy, religious, and cultural environment in Zanzibar is hostile to MSM, many of whom keep their sexual activities secret. There are few services that are MSM- or MARP-friendly. Interventions for MSM in Zanzibar, implemented by the Zanzibar AIDS Control Program, include outreach peer education and screening for STIs and tuberculosis; mobile HIV testing and counseling, as well as referrals to stationary HIV testing and counseling facilities; sensitization training for health care workers on the service needs of MARPs; an HIV risk reduction package for MSM that includes condoms, lubricants, and educational materials; community mobilization and a capacity strengthening for MSM self-help group; and integrated biological and behavioral surveillance and population estimation of MARPs. So far, more than 200 health care workers have been sensitized and trained, with 40 MSM peer educators trained; public and private facilities offering services to MSM have received HIV test kits, ART and STI treatment, and condoms. Collaboration between the Government of Zanzibar and NGO partners has been positive, and local NGOs have received capacity strengthening to become key implementers for outreach services. Community tolerance of MSM appears to be improving slowly. Recommendations include getting to know the community and local context to identify priorities before finalizing a program design, conducting ongoing advocacy, and generating and using data to reinforce advocacy efforts and guide interventions. To strengthen services for MSM, referral escorts should be used to increase uptake, mobile services should be launched to reach MSM where they congregate, and peer educators should be recruited from MSM groups.

DAY THREE PRESENTATIONS

Presentations from the workshop are posted at www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/msm_africa. The following are summaries of each presentation from day two.

Session: Intervention Strategies: Emerging and State of the Art Interventions (Moderator: Carlos Toledo, CDC, South Africa)

Update on the iPrEx Trial (Ben Brown, Desmond Tutu HIV Foundation, South Africa)

The global iPrEx study (2009–2010) was a blinded, placebo-controlled trial of the efficacy of pre-exposure prophylaxis, which involves taking antiretrovirals daily to prevent HIV. At 11 sites in six countries, 2,499 MSM participants (82 percent in Latin America, with the rest in the United States, Thailand, and South Africa) were randomized into two arms, one receiving the antiretroviral Truvada and the other a placebo. All were followed monthly for adherence and prevention counseling and for STI screening, as well as for seroconversion, metabolic effects, or other adverse events. About half of the participants were young (18 to 24 years old). The study did not isolate pre-exposure prophylaxis for HIV prevention but instead nested it within a comprehensive package of services, including regular HIV testing and counseling, adherence and risk reduction counseling, distribution of condoms and lubrication, STI testing and treatment, and regular doctor visits. The Cape Town site was one of the last to enroll and had the smallest percentage of participants. At this site, the vast majority of participants were black and colored, and most came from township communities, which substantially enhanced the diversity of the study overall. During the study, 131 participants became HIV-positive: 48 on Truvada and 83 in the placebo arm. Analysis of the data concluded that iPrEx contributed to an additional 42 percent protection from HIV in addition to the comprehensive package of services that MSM received. Overall, Truvada was well tolerated, with no significant differences between the two arms for depression, diarrhea, or death, although there was significantly more nausea and weight loss in the Truvada arm. Drug resistance was detected in only three individuals who were HIV-positive at the time of enrollment and were in the process of seroconversion. An important finding was that the level of drug that was detected in participants differed according to HIV status: only 9 percent of individuals who tested HIV-positive had detectable levels of drug, compared to 51 percent of those who remained HIV-negative. The findings show that iPrEx offers additional protection against HIV for MSM who take the drug consistently. The current open label extension study focuses on the willingness of individual MSM to take the therapy and on whether they will engage in riskier behaviors once they know they are taking Truvada and not a placebo.

Update on Rectal Microbicides: Research and Advocacy (Jim Pickett, AIDS Foundation of Chicago/IRMA, United States)

Microbicide development currently focuses on compounds using anti-HIV drugs to inhibit the virus from taking hold in the body. Rectal microbicides are an important tool for prevention, as unprotected anal intercourse—widely practiced by both women and men—is 10 to 20 times more likely to result in HIV transmission than an act of unprotected vaginal intercourse. Several promising

microbicide candidates have either recently completed testing or are being tested in ongoing phase I trials of safety, acceptability, adherence, and—to a lesser extent—efficacy. UC-781 tested varying levels of a compound based on a non-nucleoside reverse transcriptase inhibitor on rectal tissue, signaling efficacy in a small sample. MTN 006 tested 1 percent tenofovir gel; MTN 007 is testing the same gel with reduced glycerin content to lessen irritation in the rectal lining. MTN 017 is a phase II expanded rectal safety study. The RMP-002/MTN 006 is a small study comparing oral tenofovir with topical applications of vaginal and rectal gels. While participants said they did not like the gel, they also reported that they would use it if they thought it would prevent HIV infection. Next steps for the MTN trials include phase II studies with men and women who are actively practicing anal sex, and with higher-risk populations such as MSM. The U.S.-funded Combination HIV Antiretroviral Rectal Microbicide Program is funding trials of the first microbicide candidates for rectal use. Another important study is Project Gel, which will enroll MSM to test the acceptability, adherence, and safety of a tenofovir rectal gel as well as a new applicator that can be used with one hand. The first vaginal microbicide may be ready by 2015, with the first rectal microbicide available in 2017. The Population Council is currently working to develop a microbicide that can be used both vaginally and rectally. The [IRMA Project](#) has created a website, listserv, fact sheets, reports, global teleconferences, and more to advance work on rectal microbicides.

Medical Male Circumcision for HIV Prevention: Implications for MSM (James McIntyre, ANOVA, South Africa)

In recent years, randomized controlled trials based in Africa have shown that VMMC has a 50 percent or greater protective effect for men against HIV infection. VMMC trials of more than 10,000 men in South Africa, Uganda, and Kenya demonstrated a percentage reduction in HIV transmission of 48 to 61 percent. But these men were not asked whether they had sex with other men, so it is not known whether MSM participated. Extrapolating from the results of these studies, circumcision would appear to be an important component of a prevention package for the general population, but there is still too little known about its effects on anal intercourse. Analysis of available data shows insufficient evidence for VMMC's value in protecting MSM as a population from HIV; better data are needed from high-prevalence, resource-challenged MSM communities. Some protective effect has been associated only for MSM who practice insertive sex but not receptive sex. A 2010 cohort study in Australia estimated the HIV transmission rate for insertive unprotected anal intercourse at 11 percent for circumcised men, compared to 62 percent for uncircumcised men. The Soweto Men's Study also found higher HIV prevalence among uncircumcised men versus circumcised men, all practicing insertive sex. One conclusion from this study is that, in settings such as Soweto where MSM practice a high degree of sexual role segregation with other men, VMMC may reduce HIV transmission. However, a cross-sectional survey conducted among MSM in San Francisco in 2008 found that only 4 percent would be willing to undergo VMMC if it were proven to be safe and efficacious. Making the decision to get VMMC can have powerful consequences for men, depending on the cultural meaning of circumcision and the values and traditions of their communities. Because of the inconclusive evidence overall of the benefits of VMMC for MSM, the World Health Organization currently does not recommend offering the procedure to MSM and transgender people, and PEPFAR's suggested comprehensive package of prevention services for MSM does not include it. An alternative approach would be to 1) promote and offer VMMC to all men who have sex with women, whether or not they also have sex with men; 2) discuss the potential benefits of VMMC with all MSM who report predominantly insertive sexual behavior; and 3) make VMMC available for all men who request it, whatever their sexual activities.

CONCLUSION

This groundbreaking workshop engendered a rich discussion along a broad spectrum of issues and developments related to MSM and HIV. Inspired by the opportunity to exchange ideas and experiences across the borders of Africa, the participants—advocates, NGO leaders, African and U.S. Government officials, donors, and researchers—demonstrated impressive energy, creativity, and commitment to working together. The workshop also presented a venue to learn about new biomedical breakthroughs, especially in HIV prevention, and discuss their value and potential adaptation for MSM. With a very clear message of support from PEPFAR for building a political, legal, and social environment that defends the human rights of MSM and other MARPs as it works to protect them from HIV, the workshop ended on a note of optimism and with a strong sense of empowerment.

Among the many topics discussed, several were of central importance and surfaced repeatedly throughout the three days of sessions.

New evidence for program planning: There are more data available now than ever before on MSM populations in Africa, with future research initiatives in the planning and implementation stages. Many gaps in research remain, but size estimation methodologies and other approaches are helping bridge those gaps. Size estimation efforts have particular value for estimating the population size of MSM communities and thus designing tailored advocacy and service delivery programs to meet the needs of these communities. Research for MSM should be mindful to engage communities and to do no harm.

Combating stigma and discrimination: This topic—long a crippling problem in public health efforts against HIV—came up repeatedly throughout the sessions. To make programs for MSM work, MSM must feel that they can safely access appropriate and confidential health care and other services from MSM-friendly practitioners. Advocacy to end stigma and discrimination must take place at all levels—from the policymaking level, to medical staff, to the community and family levels—to definitively remove barriers to program access.

Putting human rights first: In nearly every discussion throughout the workshop, the need to build HIV strategies for MSM within a human rights framework was a central issue. This requires creating an enabling environment where sexual minorities have equal standing with all other citizens, with full legal rights and social acceptance. Fundamental to this is ending criminalization of homosexual relations and other structural barriers wherever they exist.

Few linkages to care: While MSM in many places may have access to HIV testing and counseling, there are few MSM-friendly clinics or services in Africa to support those who test positive and need care and treatment. Creating such services must become a priority for HIV strategies for MSM.

Lack of access to essential commodities: Availability of stable supplies of such essentials as condoms and lubricants must be improved. Lubricants—especially water-based—are especially scarce. Successful prevention programming for MSM requires improvement in this area.

Emerging interventions: Presentations on recent breakthroughs in biomedical prevention interventions and their application to MSM programming were a focal point of the workshop. Participants listened

with great interest to reports on research on pre-exposure antiretroviral prophylaxis, rectal microbicides, female and male condom use, and treatment as prevention, as well as on program scale-up for VMMC, to consider their potentials within the context of prevention programming for MSM.

In September 2012, PEPFAR sponsored a second regional workshop on MSM in Bangkok, Thailand.

APPENDIX I: SUMMARY OF PRACTICUM SESSIONS

Day Two: Practicum Summaries

Practicum 1: Capacity Building (Facilitator: Glenn de Swardt, ANOVA, South Africa; Discussant: Joel Nana, African Men for Sexual Health and Rights, South Africa)

Key issues raised:

- Sometimes capacity building carries negative connotations, or is seen as implying a donor-to-grantee directive from donor “specialists” who may not have indigenous knowledge.
- There are multiple challenges to successful capacity building. A primary challenge is inadequate resources: human, financial, material, etc. Capacity building also takes considerable time to do well.
- Policymakers and high-level buy-in are important. Policymakers also need capacity building.
- Measuring success in capacity building requires better M&E than currently available in many settings. M&E must gather not only quantitative but qualitative information.

Examples of successful programming/lessons learned:

- Activists and advocates must have communication skills and an understanding of the mindset and objectives of politicians and others in power who can affect policy development and funding.
- MSM and their “agenda” must take center stage in capacity building activities. Lesbian, gay, bisexual, and transgender persons need an agenda separate from MSM in negotiations with governments.
- Involvement of all stakeholders is critical to identifying service gaps at an early stage.
- Wherever homosexuality is criminalized, being “out” endangers advocates and program leaders.
- Strong advocacy at the local level organically leads to capacity building over time (e.g., short-term donor/grantee capacity building model), but donors can and do help build financial management capabilities.

Recommendations and next steps:

- Regard capacity building as a cross-fertilization process—a process of *improvement*—among organizations to increase awareness and ability to reach common goals. Necessary tools include mentoring, managing funds, and partnering, with a focus on applicability to the local level.
- Ensure that capacity building is a mutual (donor-grantee) and equitable process, where donors listen to grantees and include the needs of the community served.
- Recognize that grantees already have capacities based on local knowledge, drive, etc.

- Build the capacity of policymakers (e.g., United Nations Development Programme), including open discussions of how laws and policies are blocking progress.
- Create alliances among advocacy groups wherever possible.
- Learn how to work more effectively with other stakeholder organizations (NGOs, government, etc.) by better understanding their roles and constraints.

Practicum 2: Security and Support: Doing No Harm (Facilitator: Kent Klindera, amfAR, United States; Discussants: Mac-Darling Cobbinah, CEPEHRG, Ghana, and Dereje Tefer, Rainbow, Ethiopia)

Key issues raised:

- Despite much work planned for MSM populations, little has been done in terms of security, and little information is available on security options for MSM communities and organizations.
- There is a need to increase personal security, especially for young people, and to enhance data and communications security for computers, phones, and office documents.
- Many programs have budgets, but no money is allocated for security.

Examples of successful programming/lessons learned:

- Work with allies in country, such as embassies, civil society, and human rights groups.
- Sensitize key agencies such as the police on the rights of MSM.
- Monitor the media and raise awareness in communities so people are aware of what is going on.
- Document security threats and communicate them to all stakeholders to raise awareness of threats.
- Notify community members quickly about security issues via text messages, the Internet, or phone.
- Give security training to MSM community members as well as activists and program staff.

Recommendations and next steps:

- Include security in the new PEPFAR guidelines.
- Do not wait until trouble arrives; prepare in advance, as we know where the “hot spots” are where security issues could occur.
- Flood the media with correct information to fight security threats.
- Be aware of the sources of security threats and build the capacity of individual MSM to respond.
- Make use of software technology to document human rights abuses against MSM and their defenders. In Malawi, Uganda, Zambia, and Zimbabwe, the Democracy, Rights and Labor Division of the U.S. Department of State is supporting a U.S. company, Benetech, to work with local partners.
- Ensure the security of digital organizational records and other sensitive information, ideally offsite.

- We already know who the MSM groups are and who is working with and for them, so we should get information out about available security options as quickly as possible.

**Practicum 3: Outreach in Diverse Settings With Different Kinds of MSM Populations
(Facilitator: Brian Kanyemba, Desmond Tutu HIV Foundation, South Africa; Discussant:
Shaaban Hassan Haji, Zanzibar AIDS Control Program, Tanzania)**

Examples of successful programming/lessons learned:

- Initiating programs slowly and with a low profile is a good tactical approach.
- Identification of MSM community is central to developing and implementing outreach.
- Communicating with the MSM community is essential to a successful outreach program.
- Incentives for peer educators are important for retention and also help sustain the program.
- Identifying and strengthening individuals within the community helps build a successful program.
- Zanzibar has a very successful outreach program. Using peer outreach educators, the program provides screening for STIs and tuberculosis as well as an HIV risk reduction package. A mobile outreach services offers HIV testing and counseling and referrals. The program, a collaboration between the Zanzibar government and NGOs providing services, also partnered with a mobile telephone company to set up a hotline.
- Mali implemented a successful outreach program; a leader was identified in the MSM community who conducts focus groups to understand the needs, challenges, and service gaps in the community.
- Nigeria has a program that collects the mobile telephone numbers of HIV-positive individuals on ART and sends text messages to remind them of clinic visits as well as medication adherence.

Recommendations:

- Always begin with the most visible and accessible group within the MSM community; the larger community is very much aware of them, and this helps minimize stigma and discrimination.
- Empower the organizations as well as the individuals.
- Get the community involved from the beginning and have the community define the approaches.
- Use a holistic approach; HIV is not the only problem MSM face.
- Involve the government from the beginning and initiate public-private partnerships.
- Peer educators need to take ownership of the activities to help sustain the program.

Practicum 4: Using Technology in Working with MSM (Facilitator: Patrick Sullivan, Emory University, United States; Discussants: Steve Letsike, ANOVA, South Africa; and Paul Semugoma, Frank and Candy, Uganda)

Key issues raised:

- Which technologies should be used for which purpose?
 - Short message service (SMS): partner reduction and condom use messages; party invitations
 - Flash: callbacks from counselors
 - Call or SMS: general reminders about ART doses; reminders for testing and rescreening
 - Global positioning system (GPS): where to get condoms and lube.
- Costs of implementing these services can be high.
- Confidentiality concerns include who else is on email lists and whether the phone is shared with other family members; some MSM give a different name with their numbers.

Examples of successful programming/lessons learned:

- Phone technologies are especially useful for reminders and for requesting callbacks from counselors.
- Internet chat support groups in Uganda and Ghana have helped refer MSM to counseling; individuals register with a unique identifier, so it is possible to collect data on the numbers of people referred. Chat activities can lead to rapport building.

Recommendations and next steps:

- As you create demand for services, be sure to procure the necessary resources to sustain them.
- Identify where services can be provided based on clinic or Ministry of Health requirements.
- New methods and strategies to try include interactive messaging to collect data on behaviors, adaptive interviewing, and following people over time.

Day Three: Practicum Summaries

Practicum 1: Capacity Building (Facilitator: Glenn de Swardt, ANOVA, South Africa; Discussant: Joel Nana, African Men for Sexual Health and Rights, South Africa)

Key issues raised:

- NGOs and community-based organizations need various types of capacity building: governance, finance and administration, staff management, and strategic planning are the most common.
- Government staff need capacity building to understand MSM as a population for programming.
- A “public health approach” to capacity building can be effective but can backfire if the general population is not receiving services that a MARP gets or receives strong advocacy support externally.

- Different MARPs may fight for the same resources, especially in constrained settings. Various resources and skills needed by each MARP/MSM organization may differ because each group may represent a different MSM community or program type.

Examples of successful programming/lessons learned:

- There are good capacity building tools available in Ghana, Côte d'Ivoire, and elsewhere; FHI 360 has a useful one.
- Mentoring is extremely important, as is seconding staff, which builds capacity in specific areas such as finance/administration and technical issues.
- It is important to build a specific capacity building plan through consensus, with measurable targets that will be assessed for progress by the organization two to three years later.
- Evidence- and results-focused programs are more important than ever as resources diminish.
- Law enforcement in countries with MSM populations and programs need capacity building.
- Capacity building on advocacy is very important but can also be very tricky because of the political environment. Public health issues, human rights, or evidence on the epidemiology can be used in advocacy with governments.

Recommendations and next steps:

- Capacity building should become a “living thing,” where partners feel they are full partners within the process and their needs are identified and addressed, with some programmatic support and resources made available so implementation can result from their new capacities.
- Practical skills can be the most important capacity building for organizations, especially in hostile environments.
- Partnership framework documents developed with governments can be a very effective way to access PEPFAR resources in countries.
- The U.S. Government can facilitate study tours for capacity building, but the community-based organizations have to be very interested in—not resistant to—capacity building opportunities.
- Focus on the end products and results of capacity building to minimize any possible resistance to capacity building activities.
- Expand the funding base for MSM programming beyond U.S. Government agencies. Many private foundations are more flexible, requiring less extensive reporting and accounting procedures.

Practicum 2: Biological Intervention Updates (Facilitator: Ben Brown, Desmond Tutu HIV Foundation, South Africa; Discussants: Jim Pickett, AIDS Foundation of Chicago/IRMA, and Brian Kanyemba, Desmond Tutu HIV Foundation, South Africa)

Key issues raised:

- The results in the HIV Prevention Trial Network 052 study of treatment as prevention among serodiscordant couples are not applicable to MSM, who were not studied specifically, and for

whom the study's definition of "couple" may not be relevant. Was it ethical to exclude single people from the study?

- How do we take research and turn it into policy and programs? How do we turn science into results?
- Some governments still resist including MSM in HIV prevention programming.
- HIV treatment literacy efforts for people living with HIV have been done through such organizations as the Treatment Action Campaign in South Africa, but nothing related to literacy about HIV treatments or biomedical interventions has been done by civil society organizations for MARPs.
- How do we get civil society leadership (HIV-negative) to understand science?
- How do we get ministries of health to take note of science and include MSM in national strategies?

Recommendations:

- Engage the government in addressing the need for biomedical interventions for populations with higher HIV prevalence, such as MSM.
- Include MSM in combination prevention programs.
- Get funding to allow get more people in the MSM community to get involved in research.
- Treatment as prevention should be part of the prevention portfolio for MSM; there is a lot of interest, but not all countries are capable of undertaking this kind of intervention.
- Embed MSM protocols in non-MSM strategies.
- Create community capacity to understand, participate in, and inform research for MSM.

Practicum 3: MSM and Alcohol and Drug Use (Facilitator: Rodney VanDerwarker, Fenway Institute, United States; Discussant: Kevin Stoloff, University of Cape Town, South Africa)

Key issues raised:

- For MSM, HIV infection, substance abuse and mental health, and risky sexual behavior can become a circular problem. In Uganda, alcohol and marijuana are major issues.
- Some MSM take alcohol/drugs to "cope" with risky behavior or sex work, or with being "outed."
- What are the options where rehabilitation and substance abuse treatment are not available for the majority of those in need due to high costs and limited services?
- Most people know the message that those on medication should not use alcohol, which leads some to drink secretly and avoid taking their meds.
- Telling people what to do does not work; we need interventions that help people change.
- In Swaziland, denial of one's HIV status can lead MSM to drink as a coping mechanism.

- In Kenya, MSM are not safe in many communities. They are treated poorly—sometimes with violence—by the community, and take drugs and alcohol to cope with sex work and the internalized shame of having sex with other men (when others tell you are immoral, you begin to believe it).

Examples of successful programming/lessons learned:

What are models for addressing substance abuse among MSM?

- Busia, Kenya: To address the issue of treatment failure due to nonadherence due to alcohol use, a group of people living with HIV formed a nondenominational, low-tech and low-cost, 12-step-based alcohol group (similar to Alcoholics Anonymous), with different peer-driven groups for different demographics: youth, men, women, etc. Members' adherence to ART increased, gender-based violence decreased, and school attendance increased.
- Namibia: The country received U.S. Government funds to address alcohol and HIV by supporting social mobilization to discuss the impact of problem drinking on families and communities. The venue-based programming (bars, shebeens) engaged owners and women, although intoxication and violence made it difficult to continue interventions. The U.S. Government hosted a consultation on HIV and alcohol use in Windhoek in April 2011.
- Uganda: Substance abuse treatment is available only in emergency settings. An NGO with an MSM-targeted program established a pilot project to address mental health. Many MSM are traumatized due to stigma, discrimination, and community/political abuse, as well as low self-esteem.
- The AUDIT Intervention uses motivational interviewing in primary health settings. The PRIME project improves the skills of public health care workers to address substance abuse.

Recommendations and next steps:

- Give MSM culturally competent services that are nonjudgmental, gay-positive, and accepting to alleviate the “minority stress” and internalized stigma that they experience. MSM with substance abuse issues also need community-based places to go to.
- Lesotho needs advocacy for family acceptance of homosexuality and for communities to understand and accept. Many members of the lesbian, gay, bisexual, and transgendered community leave home because they are not accepted or supported financially. Some get involved in sex work, which leads to risk behaviors that can lead to HIV infection.
- Address human resource issues. Counselors need to acquire the skills to do motivational interviewing and make referrals, while more mental health or substance abuse counselors are needed, as well as psychologists; programs need an extra step beyond brief motivation interviewing. Other cadres of health care workers need substance abuse tools.

Practicum 4: Policy Analysis and Advocacy to Increase Effectiveness of Human Rights and Address Stigma and Discrimination (Facilitators: Ron MacInnis, Health Policy Project/Futures Group, United States, and Nguru Karugu, Public Health Innovation, Kenya; Discussant: Kene Essom, African Men for Sexual Health and Rights, South Africa)

Key issues raised:

- Religion trumps science in much of African society, but science is critical for advocacy. We need data to build credibility with stakeholders in order to use advocacy.
- Advocacy by MSM is important but requires technical and policy assistance and strong partnerships.
- Countries need a basic budget for research and advocacy; in West Africa, which has concentrated epidemics, resources are not available, even though HIV prevalence among MSM is increasing.
- Including MSM in GFATM activities does not guarantee funds.
- Programs are currently donor driven; local ownership is necessary.
- Sometimes LGBT rights are more than difficult to attain than HIV services.

Examples of successful programming/lessons learned:

- Kenya used survey data to drive its national agenda on MSM.
- Ghana successfully focuses on MARPs rather than MSM.
- In hostile environments, focusing on male sexual health with MSM-friendly services may be a good option.
- Despite instances of stigmatizing news coverage in Africa, the media have been useful as advocates when they are educated and supported. It is important to proceed incrementally to avoid a backlash.
- Burkina Faso works with the USAID Health Policy Project to include key populations in national strategic planning.
- The UN agencies conducted targeted sensitivity training to and promoted honest discussion among their staff, both international and locally hired, to improve internal attitudes and practices.

Recommendations:

- Build partnerships with government and provide data to support arguments for including MSM and other MARPs in programming.
- Analyze the country situation and work incrementally with a clear vision and long-term strategy.
- Explore ways to work with the media and police so they become stakeholders rather than obstructionists.
- Size estimates of key affected populations are valuable for identifying needs and resources required, and should be developed and used for advocacy.

- Work at the local level with advocates and community leaders and develop trust within the community. Train U.S. Government staff and stakeholders when appropriate on diversity and sensitivity.
- Develop trust with the community.
- Even where MSM are hidden, reach out—they are there.

For more information, please visit aidstar-one.com.

AIDSTAR-One

John Snow, Inc.

1616 Fort Myer Drive, 16th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

Fax: 703-528-7480

Email: info@aidstar-one.com

Internet: aidstar-one.com