Fostering evidence-based HIV programming for men who have sex with men (MSM) in sub-Saharan Africa

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**Acknowledgments**

The Anova Health Institute, in collaboration with the HIV/AIDS Department of the World Health Organization and The Global Fund to fight AIDS, TB and Malaria, organised this meeting.

The organisers would like to acknowledge all of the support that ensured this meeting’s success:

Organising committee: James McIntyre, Annette Verster, Rachel Baggeley, Frank Lule, Michelle Rodolph, Mauro Guarinieri, Ade Fakoya, George Ayala, Carlos Caceres.

Administrative support: Heather Humphreys.

This report is based on the proceedings of the meeting, and the views expressed do not necessarily represent those of the Anova Health Institute, World Health Organization of the Global Fund, as the organisers of the meeting.
The meeting started with an opening and welcome session.

Ms Mmapaseka Steve Letsike, representing the South African National Aids Council (SANAC) welcomed participants to the meeting and to South Africa, and emphasised the importance that SANAC is giving to the issues of key populations and in particular to programming tailored to men who have sex with men (MSM).

Sarah L. Barber, the World Health Organization (WHO) Representative in South Africa officially opened the meeting, emphasising the crucial need to better address key populations, and in particular MSM, because of their elevated risk, high HIV prevalence rates and challenges around discrimination and stigmatisation.

The WHO provides guidance and recommendations on evidence-based treatment and prevention. New global consolidated ART guidelines will be launched in July and the WHO has released specific recommendations for prevention and treatment among MSM. At a country level WHO takes the lead to assist countries to improve access to antiretroviral treatment (ART) and will need to work with all partners to make health services more attractive to MSM and other marginalised populations. WHO also appreciates that prevention is critical in reaching treatment targets, and recognises the need for low-threshold and community-led programmes to reach the hard-to-reach with prevention methods and information in order to halt new infections. WHO works closely with the Global Fund to support countries to implement the right package of interventions in order to address HIV effectively.
Mr Mauro Guarinieri from the Global Fund (GF) gave opening remarks on behalf of the GF, recognising the timeliness and importance of this meeting, and the need to increase evidence-based HIV programming for MSM in sub-Saharan Africa.

The introductory session provided background on the scale of the problem and priority needs. Dr Frank Lule from the WHO presented on the magnitude of the HIV epidemic in key populations in the region. Dr Kevin Rebe, from the Anova Health Institute described the clinical priorities in the response to HIV for MSM and Mr Owen Ryan from amfAR discussed issues around financing the response to HIV for MSM in southern Africa.

A second session addressed the current response and challenges. Dr George Ayala from the MSMGF examined social/structural predictors of access to HIV services among African MSM and the implications for programme design and delivery. Prof James McIntyre, from the Anova Health Institute presented on key barriers to effective programming for MSM. Mr Joel Nana from AMSher discussed a human rights approach to MSM programming.
The aim of the conference was to discuss HIV prevention and treatment programming for men who have sex with men (MSM) in practical and pragmatic ways, and to find concrete ways to improve access to services and treatment for MSM.

Dr Frank Lule – WHO, AFRO

The Magnitude of the HIV epidemic involving MSM and other key populations in the region:

» The prevalence of HIV in MSM and other key populations in Africa is disproportionately higher than the general population, and is on the increase.

» More needs to be done to establish the estimated size of the at-risk populations, and targeted interventions are needed.

» All strategies and interventions should involve the population concerned – and be peer-led where possible.

» There is a lack of access to clinically competent and appropriate health care, and as a result, many MSM do not know their HIV status.
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» People who are at risk of HIV infection are often marginalised from the broader community, stigmatized and discriminated against.

» Interventions should generally be implemented at places where the population concerned lives, works or congregates.

» Service interventions need to operate continuously or be regularly repeated to ensure that new members of the population have access to services.

Kevin Rebe – Anova Health Institute

Clinical Priorities in the Response to HIV in MSM in Developing Nations:

» MSM are not a homogenous group, and their health care needs vary.

» MSM generally practise poor health-seeking behaviour, but sexually transmitted infections (STIs) can be a good entry point to care (although it would be preferable to draw MSM into health care before they contracted infections).

» While the STIs that MSM contract are mostly the same infections as heterosexual men and women contract, screening, prevention and treatment strategies are essentially not available to MSM.

» This is largely because there are still high levels of criminalisation and stigma in many countries – 76 countries criminalise MSM. Services in most countries do not screen for asymptomatic infections.

» This group is largely hidden to the health care sector, and creative ways are needed to draw MSM into health care and manage their issues.

» This area is under-researched and under-funded in Africa. Globally, MSM experience high levels of stigma and discrimination. It is important to frame MSM-targeted health care around holistic health services – a Health model – but also to frame this as a Human Rights issue.

» Knowledge around the acceptable labels and identities is very important. Besides physical health, mental health and awareness around self-medication and use of recreational drugs is also necessary.

» Community education on MSM issues is vital.

Owen Ryan – amfAR

Financing the response to HIV among MSM in Southern Africa:

» Findings from a recent amfAR report on funding of MSM services in Sub Sahara Africa were presented. (Full report available at http://www.amfar.org/uploadedFiles/_amfarorg/Articles/Around_The_World/GMT/2013/MSM%20Global%20Report%20051413_b.pdf)

» The study showed that funding trends for MSM-targeted HIV services are changing, mostly for the better.
Session one

» The problem is that practice lags far behind policy. The Global Fund Strategy in relation to Sexual Orientation and Gender Identities (SOGI) and PEPFAR guidance on MSM have produced unclear results.

» The systemic neglect of this group has had negative results.

» It is not sufficient to decriminalise MSM sexual activity - the stigmatisation, discrimination, violence, and lack of access to basic commodities (notably condom compatible lubricant) need to be addressed.

» There has been a significant improvement since 2008 - US Government (PEPFAR) targeted funding is offering opportunities for key populations. These programmes are being embraced from a public health perspective (although not necessarily from a human rights one).

» Unfortunately, this is not happening fast enough to halt the HIV epidemic.

Discussion

The discussion centred around two main points: Firstly, stand-alone male sexual health clinics – not specifically for MSM – with nuanced branding to draw MSM in, may be a good starting point. Care educators and community ambassadors are needed to educate the community and draw MSM into these clinics. These clinics must have staff sensitised and trained to deal with MSM issues – how to do examinations and give competent service.

Secondly, the idea that being “gay” is un-African and is regarded as a foreign import must be unpacked and discussed.
George Ayala – MSMGF

Social/Structural Predictors of Access to HIV Services among African MSM - Implications for Program Design and Delivery:

» The Global Forum on MSM & HIV (MSMGF) works for equitable access to effective HIV prevention, care, treatment and support services to gay men and other MSM, while promoting their health and human rights worldwide.

» It aims to expand the coverage of high quality HIV-related services, to promote and protect human rights and to increase investment for effective health and rights-focused programs. This is achieved through promoting improved knowledge of MSM and HIV through research, broad-based information exchange and communication as well as partnering with well-prepared MSM advocates, linked to each other and to broader MSM networks at the global, regional, and national levels.

» HIV is disproportionately clustered in specific groups of the population, and there are reasons for this

» MSM globally are nineteen times more likely to be HIV positive than the general population. Only 24-55% of MSM are reached by HIV prevention and care services.

» It is not enough just to look at barriers (homophobia and provider-stigma, discrimination, violence) – ways in which the services can be improved must be investigated.
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» Comfort with providers, community engagement and connection to a gay network were found to be significant enablers for increasing access to services for MSM.

James McIntyre - Anova Health Institute

**Key barriers to effective programming for MSM:**

» MSM are becoming a priority for targeted health interventions globally.

» This is a marginalised, often invisible but significant grouping of men.

» Many MSM in African settings also have sex with women.

» Prejudice prevents MSM accessing health services and research opportunities. Institutionalised homophobia and internalised homophobia and fear make the provision of MSM-focused services or enrolling MSM into studies a major challenge.

» There is limited understanding and data about sexual behaviour and poverty and unemployment. MSM generally have poor experiences of mainstream health services.

» There is a lack of political leadership and role models. It needs to be acknowledged that different men have different needs, do different things, hear different messages, and are engaged in different ways.

» Social media and technology can be used to overcome barriers – there is a need to reach young MSM in their spaces.

» The false divide between biomedical and behavioural strategies must be recognised. Outreach activities should promote holistic men’s health, and not only HIV risk. MSM-focused services will provide a “safe place” for research to better understand MSM needs.

» Implementation of successful biomedical interventions may also provide opportunities to refocus on behaviour modifications, including alcohol use, delaying sexual debut, decreasing HIV risk from drug abuse, and including needle exchange programmes and reducing the risk from multiple concurrent partnerships.

» The focus should be on how to achieve these aims.

Joel Nana – AMSHER (African Men for Sexual Health and Rights)

**Enabling environments: a human rights approach to HIV prevention among MSM:**

» 39 countries in Africa have, or are in the process of enacting, laws criminalising same sex activities.

» MSM are the target of arrests and violence. Ignorance around same sex sexuality is a major challenge.

» There is currently increased attention to MSM – they are being included into
National Strategic Plans and decision-making bodies (National AIDS Councils, Country Coordinating Mechanisms).

» There has been improvement in the quality of MSM-led programming. But there are major differences between Human Rights standards and practices. Programmes should intentionally further international human rights. There should be an emphasis on capacity building with a shift of focus from violations to fulfilment.

» We need to ensure that all members of society have access to stigma-free services. Community-generated advocacy on HIV should be recognised as a legitimate process. Those who will benefit from the process should always be included in the process.

» Explicit guidance should come from the target population of MSM who are intended to benefit from the programmes.

» A human rights approach will support the formation and legal registration of MSM organisations and ensure that there are no prohibitive legal and policy barriers that prevent MSM from accessing necessary information and medical care.

» In-country negotiation processes and proposals should ensure that programmes protect and promote the human rights of all persons, particularly the rights to equality, non-discrimination, access to healthcare and access to information as well as equal access to justice and redress for violations of human rights.

Discussion

The issue of violence can be analysed on two levels – between couples and in the public domain. Both are human rights abuses, aided by homophobia and a lack of facilities to report these. People need access to justice. A human rights approach shapes the relationship with governments. There is little leadership in terms of human rights violations. But a focus on medical and behavioural issues and the interdependency of these issues will help to deal with the rights issues.

It must also be acknowledged that these issues are not only related to MSM but also other key populations – there is a need to resource these special groups and to fund the tools to provide the evidence as to why these need to be addressed.

Structural changes must enable people to feel self worth and get the care and prevention treatments they need. Donors and interested international parties must facilitate African voices by providing leadership and funding, a human rights approach and a challenge to African leaders. A rights-driven approach makes sure that everyone has access to services.
Annette Verster – WHO

WHO Guidance on Prevention and Treatment of HIV for MSM:

» The WHO has issued guidance for the “Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: Recommendations for a public health approach 2011”.


» The Guidelines focus on the prevention and treatment of HIV and other sexually transmitted infections (STI) among men who have sex with men (MSM) and transgender people. They include evidence-based recommendations, the summary and grading of evidence, implementation issues and key research gaps. Although the focus of this guidance is on low- and middle-income countries, WHO recommends that this guidance be available for MSM and transgender people in high-income countries as well.

» The document presents good practice recommendations that focus on ensuring an enabling environment for the recognition and protection of the human rights of MSM and transgender people. Without such conditions, implementation of the more specific technical recommendations is problematic.

» The WHO focuses on developing normative guidance – recommendations for regions and countries to implement and guide donors: not just what needs to be done but how to do it – guidance to set targets and measure progress.
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» WHO Regional offices and country offices should try to get health authorities to take the guidance seriously, and need to build bridges and advocate interventions as much as possible.

» There are WHO offices at country level that have country level specific guidelines for MSM, drug users and sex workers. Organisations who work with these groups should approach WHO at a country level for assistance.

» Recommendations are a powerful advocacy tool and framework for policy makers. These should be adopted in countries towards inclusive service provision.

» Decriminalising key population groups is vital for successful responses.

» The WHO guidance is all based on evidence and not on individual views or political considerations.

» The WHO is going to release additional tools on treatment guidelines in mid 2013, which encourage capacity building at all levels.

» New guidelines are likely to promote the earlier initiation of ART (CD4<500) and pre-exposure prophylaxis (PrEP –use of ARV in HIV uninfected people to block the acquisition of HIV infection).

Panel session
Programme Examples 1: Services and training

Chaired by Alasdair Reid, UNAIDS

Country participants presented in this panel on their experiences and programmes that address health services and training of health workers.

These included topics such as: Ways of working in ‘difficult’ environments: Addressing stigma and discrimination to improve service delivery, including mix of services offered in current programmes; service delivery issues, outreach, training of staff, and links with other services.
Malawi

David Kamkwamba, JONEHA – Journalists living with HIV and AIDS

» Malawi has a high prevalence of HIV amongst Sex workers and MSM – disproportionate to rest of population.
» Homosexuality is illegal in Malawi.
» All HIV-infected people, not just MSM, are stigmatised in Malawi.
» Information on MSM is limited and a more comprehensive study is needed to understand the dynamics related to accessing services in Malawi.
» People living with HIV are denied rights. Advocacy Materials need to be developed in the main languages of the people of Malawi.
» Pre and in-service training for service providers needs to be given.
» The results from Malawian research on the Stigma Index suggest that protocols and curricula should be revised prepare health providers to provide non-judgmental and non-discriminatory services to people living with HIV. It suggests that there should be support for broad-based social and community awareness-raising and mobilisation as part of efforts to eradicate stigma and discrimination. HIV-related stigma and discrimination reduction, as well as support for promising programmes, should be prioritised.
» JONEHA proposes sensitisation meetings with decision makers, CCM, PRs, MPs, Principal secretaries, faith based organisations, the law commission, the law society, and media practitioners and the development of policy briefs and media products with differentiated audiences.
» We MUST do something about the stigma associated with MSM and HIV. Deep and intolerant religious values must be challenged.

Kenya

Ashirah Halaki, Kenya Red Cross

» In the recent past, Kenya has developed service guidelines and other programming tools, facilitated access to funding, supported key population groups to form organised groups, trained members of key population groups as peer educators and trained health workers.
» Kenya has also facilitated dialogue with policy makers for the
implementation of MSM programs and garnered international support in the form of resources, best practices and technical assistance.

» The Global Fund Round 10 project has assisted in the delivery of a minimum package of services to MSM, including HIV counselling and testing, peer education, outreach, distribution of condoms and lubricants and formation of support groups.

» This is implemented largely through a peer educator system, which is proving successful in drawing MSM into the healthcare system and offering them basic services.

» The programme suggests that the visibility of MSM issues should be amplified and that ways to increase MSM access to resources be found.

» This should focus on a holistic approach, which includes nutrition and general wellness. Interested parties should facilitate the creation and dissemination of an evidence base for a better public health response on MSM issues.

South Africa

Glenn De Swardt, Health4Men, Programme Manager at Anova

» The Anova Health Institute’s Health4Men project offers direct services to MSM in South Africa. It was established at the behest of the Department of Health (DoH) and works closely with the DoH and the South African national AIDS Council (SANAC) to influence health policy.

» Health4Men has developed comprehensive guidelines for MSM clinical care.

» Two MSM centres of excellence have been set up, as well as four additional supported sites, and there are currently over 6 000 MSM in care in the Centres of Excellence – being assisted with STI, HIV management and comprehensive medical health care.

» The clinics promote sexual health and community engagement such as the challenging of homo-prejudice through peer educators and media awareness campaigns.

» The model adopts an Afrocentric approach and aims to sensitize health care workers through training and medical mentoring.

» Health4Men will extend training, mentoring and service support to an additional 100 centres in five provinces in South Africa over the next few years, through a PEPFAR-funded project.
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» Innovative prevention and health information communication approaches, including mobile phone based services will be used in addition to facility based services.

Discussion

Countries are at different stages in acknowledging the need for and establishing MSM targeted services. Invisible populations are often part of social networks and virtual communities and may be reached through social marketing. Cell phone mobi sites can provide all sorts of information about sexual health – and users can pose anonymous messages. It is important to get the current terminology right so that people can identify with the message.

The importance of leadership was raised – a methodology to engage leaders in managing HIV and AIDS – prevention works, leadership helps and a focus on stigma is important.

Much more data is needed - more information about who MSM are, the size of the group and how to reach them is important. Stand-alone clinics as opposed to ones integrated with other health care were discussed. It is important to know your epidemic, know your response, know your client and what they need and not to pigeonhole – people must be treated holistically.

Panel session

Programme Examples 2: Prevention and testing

*Chaired by Amitrajit Saha, UNDP*

Country participants presented in the second panel session on prevention and HIV testing interventions and strategies for MSM, including: Intervention strategies: Condoms, innovations for an old solution; HIV testing and counselling and linkage to HIV care and ART.
Kenya

Peter Njane, ISHTAR – MSM health and well-being

» ISHTAR offers counselling and testing, referral to MSM-friendly care centres, the distribution of lubricants and condoms, Safe Sex workshops, Open Forum Discussions, Peer Education and Counselling as well as outdoor activities and advice to MSM in terms of setting up their own businesses.

» ISHTAR makes a number of recommendations, including the amendment of the Penal Code to decriminalize sodomy, sensitization of health care providers, awareness creation among MSM peers to reduce stigma and discrimination, enhancing referral systems, and funding specifically for MSM-led groups.

» Creative ways to involve people in clinics must be explored which will entice people to come for treatment.

Malawi

Gift Trapence, CEDEP

» MSM Peer Education programmes have been introduced in six districts in Malawi (USAID funded).

» Government service providers need to be trained and sensitised.

» The Malawian Government has shown its commitment to supporting MSM programming. There is a push to link peer educators with service providers.

» One of the challenges is that 90% of MSM do not know their HIV status.

» Another is to provide health care services, as well as distribute condoms and lubricant, to rural-based MSM.

» There is a need to balance public health and human rights approaches.

» Good research is currently underway in Malawi in the form of two studies – a population estimate (UNDP, UNAIDS) and Combination HIV Prevention: a feasibility study among 100 MSM in Malawi (USAID and John Hopkins).

» There is also advocacy to influence policy and legal reform.
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» The National AIDS Council has funded an MSM programme for the first time.
» All these programmes need more commitment from policy makers.

Mozambique

Danilo Da Silva, Lambda

» Interventions that are currently underway by Lambda in Mozambique include projects in five cities where peer educators work amongst small groups of people – these are ambassadors who distribute materials, talk to clients, and distribute free condoms and lubricant.
» The organization does not have the capacity to provide services so they provide referrals to health centres. They also train health providers, who are distributed across nine health centres.
» The challenges they face are similar to those in other countries, but the resources are particularly poor.
» MSM have no representation in decision-making and very little access to resources. NGOs find it difficult to provide quality programmes.

Discussion

There is a need for effective evaluation and monitoring systems. The issue of running parallel systems is tricky – policy-making etc. needs a holistic approach. Much more research and documentation on MSM is needed.

The importance of condoms and lubricants, and appropriate products, must be highlighted. There is a need for public services for MSM as part of comprehensive health care.

There is a need to understand the Characteristics of MSM in Sub-Saharan Africa, including questions such as: What particular aspects play a role in communities? Can community groups receive funding from major donors and if not, how can this be remedied?

NGOs should develop a model that can be tested, piloted and handed over to governments so that these services can reach a broader part of the community and be sustainable. It is important to talk about the role of the players and the funders in this discussion – this communication is vital. It is important to use the vehicles that already exist in the countries.
Participants in the third panel presented examples of working intervention strategies, including: STI prevention, screening and treatment; access to care and treatment; linkage to care and evaluation; and emerging interventions.

South Africa

Jacques Livingston, ICAP

» As part of South Africa’s National Strategic Plan, substantial support to target MSM and other key groups is needed – which focuses on the specific needs and realities of MSM.

» This involves working with organisations currently working with MSM and others who were not doing so previously but who have expressed a willingness and capacity to work with MSM.

» MSM experience access challenges for care and treatment, along the prevention-to-care continuum – a range of services and interventions aiming to keep people healthy, by preventing disease, promoting health and treating and managing illness – functions at primary and secondary health care level.

» This requires partnerships, and cannot be provided by the health sector alone.

» A “Community of Practice” (CoP) approach is needed – a group of people and organisations working towards a common goal. This will involve all sorts of service providers working under the same frame, who can provide a collective, integrated response.

» ICAP’s project is establishing this approach in five provinces in South Africa.
Lesotho
Lineo Sheriff Mothopeng, Matrix

» MSM do appear in the national AIDS strategy in Lesotho as a high-risk group.
» Same sex is illegal in Lesotho.
» All size estimations of at-risk groups tend to focus on females. People believe that MSM are a marginal group in relation to the rest of the population.
» Respondents to a recent survey mostly use condoms and reported being tested for HIV.
» STIs are prevalent – more intervention is needed in the health system.
» There is a need for an effective HIV programme that includes MSM as a group.
» Most men in same sex relationships don’t disclose their preference to health care workers because of discrimination, which limits the efficacy of any interventions. This must be addressed in order to treat HIV and STIs.
» MSM do exist in Lesotho and the group can be accessed. They must be addressed as a group to discover more about their sexual behaviour in order to intervene. Not enough data at the moment exists to conduct a systematic review of MSM information.
» The Lesotho government is planning a technical working group targeting most at-risk groups.

Namibia
Friedel Dausab, DMC Services

» Namibia is in the process of gathering high quality data on MSM– led by the Ministry of Health and Social Services.
» Transgender people have pulled out of the current study because it was perceived as not sensitive to their needs, but the communities are starting to trust the study.
» There are broad-based civil-society partnerships underway in Namibia.
» Condoms and lubrication are distributed via safe sites.
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» There are attempts to intervene to change individual and group behaviour. This is linked to HIV disease-progression monitoring, ART monitoring and STI services. Most of the good work takes place in urban centres.

» The challenge is to link care and clinical services. Organisations working with anonymous clients use a unique identifier for MSM and transgender people to monitor their progress and whether they are accessing health care and in an attempt to keep them in care.

Discussion

The importance of strategy underlying delivery must be noted. It is important to pay attention to the process as we pay attention to interventions. There are still huge data gaps in some places. The links between civil society and government are important, as is review of National Strategic Plans for components for MSM prevention and intervention.

Implementation of MSM targeted services has been a challenge, but MSM could guide governments in this regard. Strategies are needed to bring organisations working with key population groups together. One suggested approach was to link cost effective organisations that share spaces and costs, meet regularly, share knowledge, expertise and information, address criminalisation etc.

Information systems are important because they community organisations often refer people to health care services but services do not feedback on the referral process. It is hoped that the Namibia review will provide a good example of tracking MSM through health services – because little is known about where in the process people are lost.
An overview of the new Global Fund (GF) funding model was presented. This includes:

» National Strategic Planning is supported as long as it is robust (actionable, based on good data)

» Country dialogue: the main feature of this is that it should be a fully inclusive process, including at the CCM level. The GF wants to address gaps in representation of MSM and other key populations, whilst recognising that some constituencies might not want to be publicly represented because of specific politics.

» Concept note (25 pages, country explains epidemic and the intervention, budget, where the money’s coming from) (advised and supported by GF)

» TRP review (A specific seat on the Technical Review Panel (TRP) has been approved as focal point for the MSM community).

» Grant-making which must reflect the original idea.

» Countries need to realign research and services in order to match the epidemic.

» Information is often available to communities long before it is to technical partners, so the GF needs to make sure money is properly invested where it will really make an impact. The GF is not starting from scratch so all old policies are still in place. The new funding model is a delivery mechanism in transition, the GF
is explicitly encouraging groups to produce shadow reports to demonstrate where things are going well, or there are problems.

» GF needs to know where core goals are addressed and to share information about upcoming dialogues. The main message about country dialogues is that the GF wants to make sure it is not moving from its core principle – watchdogs should tell GF where countries are doing well and where they could do better.
Carlos Caceres, from the Cayetano Heredia University, introduced the group work sessions, noting that, although there is agreement that more needs to be done in this field, it is often unclear what to do and how to do it. Countries are at different points of departure in their response to MSM, and the goals of governments and civil society are often not the same. Goals and strategies for different countries may vary according to political and legal climates; the funding environment and programmes that are already in place.

Country situations are diverse with regard to numerous factors, including:

- HIV Epidemiology
- Availability of epidemiologic data
- Interventions may still be needed everywhere
- Availability of social, demographic and social networking data
- Identities and communities
- Context in relation to laws, human rights and sexual diversity
- Level of homophobia, stigma & discrimination
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- Access to health, education, justice, labour
- Access to HIV prevention and care
- Existence and visibility/role of MSM movement
- Level of effective response to MSM epidemic
- Concrete funding opportunities

Participants worked in two groups to discuss the WHO guidance, and their reactions to the country example presentations and to identify the main difficulties and grasp the barriers that need to be overcome. The groups were tasked to discuss effective and innovative strategies to confront the identified barriers.

Participants broke into two groups: one of civil society participants, facilitated by George Ayala (MSM GF), and one group of government and international organisation participants, facilitated by Frank Lule (WHO).

Civil Society group feedback

» The biggest challenge is that not enough money flows through to MSM implementers on the ground level because there are usually one or two Principal Recipients (PR) of Global Fund grants and sub contracts are not always available.

» There is a lack of capacity in community-based organisations and questions of accountability were raised – who is accountable for the funding? How do we build capacity? How much money is available?

» Another issue is that not all PRs or organisations understand what the Global Fund Procurement Support Services (PSS) means. The financial and operational risk resides at the PR level, but this should not prevent a PR from being innovative.

» Organisations are restricted by policy. There is a need for more latitude and for MSM organisations to get involved in planning AND implementation, at the Country Coordinating Mechanism (CCM) level and working group level – to provide input from the ground up.

» MSM need to be represented on all bodies.

» There should be more flexibility in the GF for ways in which non-registered community organisations can be funded.

» The sensitisation of policy makers and advocacy in government are issues that
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must be addressed.

» MSM must be heard in the planning part of funding cycle too. Generally PRs have experience but they don’t share their information and planning – this could be addressed

» A Standard assessment tool for organisations is needed to help fill gaps.

Government and agency group feedback

» The group included participants from Lesotho, Zimbabwe, Malawi, Mozambique and SA. The group discussed the main barriers and effective strategies from a government perspective.

» Identified barriers include:

» Punitive laws against same-sex relationships,

» Problems with donor funds,

» A lack of political will to acknowledge and support MSM,

» Stigma and homophobia issues,

» A lack of evidence of the burden on MSM,

» A lack of formal structures for MSM service provision

» And a lack of advocacy from countries.

» Current initiatives include studies being carried out to define the magnitude of the issue, and the inclusion of MSM in national strategic plans.

» AIDS Councils and Commissions are supporting MSM, commodities are being procured and the use of ambassador models as link in care and support is in place in some settings.

» Countries must acknowledge the existence of MSM as an at-risk group.

» Countries and agencies need to work with civil society in order to offer comprehensive health services for men.

» Policy changes and penal reforms on same-sex relationships are needed.

» The development of skills for health care workers to be competent, sensitised health care providers is essential.

» Men’s health care clinics must be established. Male circumcision clinics – which are voluntary – provide a good entry point to get all sorts of men into clinics, although clients tend to be predominantly young men.

» It is difficult to change laws, but strategies to work within existing laws could be used to offer MSM services could be offered in ways analogous to the way in which services are offered for post-abortion care – despite abortion being illegal in many countries.
In the second group work session, participants broke into country teams, which included both civil society and government and agency participants.

Groups were asked to identify what is still needed, what is possible in the short term, and what the role of key actors could be.

The three key questions posed to each group were:

1. What is needed in relation to aspects or programming?
2. What is possible now?
3. What is the role of key stakeholders?

**Malawi feedback**

**Question 1 - What is needed in relation to aspects or programming?**

**Evidence**

» Survey for MSM is underway covering seven sites  
» Will include HIV prevalence and risk factors for HIV and STIs.  
» The report should be out by October 2013.
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Prevention services

» Need to scale up what we have started, maximising on strengths – peer education started. Want to scale up HIV testing and counselling

» Need to extend voluntary medical male circumcision.

» MSM -targeted – need for Information, education and communication materials in terms of empowering individuals

Care and treatment

» Develop linkages with existing structures – sometimes we duplicate activities and lose focus.

» Specifying the needs of MSM in the country.

Legal frameworks and human rights

» A key issue to change the situation is to focus on advocacy for local adoption of international human rights instruments – Malawi is party to many of the ideal instruments but has issues of acceptance and implementation on the ground.

» In terms of advocacy, bridges must be built with MPs, the law society, Malawi Human Rights Commission as well as the justice system and law enforcement.

» There is a need to advocate for an HIV bill – with specific provisions to protect MSM interests.

» Legal report – also key to create a favourable environment in Malawi.

» A human rights-based approach on HIV and AIDS programming.

» Watching for human rights abuses for MSM and LGBTI people. Where Human Rights violations are identified, they should be documented — for example, reports of girls suspected of being lesbian sent from school or people being hired and then discriminated against because of sexual preference.

Access to education and labour

» Need to work on capacity building – individual (skills development), institutional (implementation of programmes) and national level (strategic programmes that consider and improve MSM needs)

Homophobia and discrimination

» The media has a central role in sensitisation programmes.

Community organising

» Engage communities to empower them with information and get their feedback consider empowerment workshops around the country.
Question 2 - What is possible now?

- Completion of the MSM survey.
- Information to all target areas.
- Recommendation to Minister of Health for men’s health clinics, including links to male circumcision clinics – maximise on existing opportunities.
- Advocate for MSM issues to be included in the HIV and AIDS bill – November 2013.
- Cost all the work that needs to be done.
- Work with CCM – new funding model started but we want to ensure that we’re on track with inclusion of MSM activities.

Question 3 - What is the role of actors in strengthening the response?

- The Global Fund and other donors can help with finances and negotiate with Malawi for a high impact agenda for MSM – advocacy for policy and technical guidance – to ensure specifications are in place.
- Government systems and structures need to be looked at in terms of relevance to MSM so we can implement that which is relevant.
- Benchmarks are acceptable but we need to be able to monitor our progress. We expect our government to promote and protect human rights.
- Promote human rights and consider changes to discriminatory laws Parliament must amend laws which violate human rights of MSM
- Develop linkages to draw support from appropriate places at given time.
- Must be seen to be implementing that which we have planned – by key stakeholders.

South Africa feedback

Question 1 – What is needed in relation to aspects or programming?

Evidence

- Surveillance is happening in major cities, for key populations, with plans for specific MSM surveillance projects, but there is not enough national surveillance, especially in rural areas
- More social science research is needed on sexual practices – who does what to whom, and where, and how are these relationships are constructed?
- How big, how concentrated and where would programmes have the most impact?
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» There is a need to include transgender populations in these activities – have been almost completely ignored. An example was given that many sex workers accessing services offered by the Sex Worker Education and Advocacy Taskforce (SWEAT) are transgender but are accessing services through MSM programmes. Transgender people are falling in the shadow of MSM without their specific needs being addressed.

» Transactional sex and sex work needs to be studied and understood.

» There is a need to recognize that even when "MSM" are being discussed, we often are actually thinking about gay men and not situational gay sex such as in prisons. There are still problems of identity and behaviour: sometimes needs are not met according to the relevant behaviour.

» Social and structural factors increasing the burden of disease are being overlooked.

» We need to remain aware of MSM diversity. We don’t know enough about sub-populations of MSM: for example, there are no local data on HIV prevalence in transgender populations. We need to consider sub-populations more.

» Understanding risk forms part of social science needs.

Prevention services

» Need to understand what prevention interventions work.

» Linkage to care is a vital part of the prevention care continuum.

» There is a need for more targeted behaviour change strategies – could specifically target groups such as MSM youth with IEC material and specific targeted awareness programmes.

» STI screening for MSM needs to be strengthened

» Knowledge of HIV status: need to consider whether HIV testing and counselling is reaching the right people?

» Biomedical prevention strategies were considered:
  
  – Condoms – understanding use and issues around which condoms are distributed, where and how. MSM (and all men) should not need to go to clinics to access condoms. What alternative distribution networks can be considered e.g. outreach workers, shebeens or taverns?
  
  – Lubricant – need more supply but also more understanding about the use of lubricant. Better distribution networks require collaboration between the Department of Health and community networks. There is currently no national supply of lubricants: government needs to look into supplying lubricant into areas of need.
» ART prevention methods:
  - Looking forward, prevention NOW is cost saving in the future.
  - Treatment as Prevention (TasP) – MSM might benefit from raising CD4 count criterion for initiation of antiretroviral therapy, which could protect against transmission to negative partners, given the higher risk of transmission through unprotected anal intercourse
  - Achieving absolute coverage of antiretroviral treatment for HIV positive MSM at the current CD4 threshold of 350 would have an impact on prevention (needs community work and access improvement to improve linkage to care)
  - This may be an advocacy point to government to consider raising the CD4 threshold.
  - Pre-exposure prophylaxis (PrEP) – there is an urgent need for pilot programmes for PrEP for MSM as evidence of effectiveness in this population is building.
  - Although a national PrEP programme is likely to be far off, it would be possible to build experience or real life use of PrEP from demonstration projects.

» The gaps in accessing prevention services need to be identified. Why are MSM not accessing state services?

» Behaviour change is often easier in setting where biomedical interventions exist. MSM need to understand behaviour and why change would be beneficial.

» Links with structural issues such as building community and safe spaces

Care and treatment

» Stigma and discrimination regarding care affects access to ALL aspects of health care.

» Knowledge of issues such as anal STI need to be integrated into services

» Suggest twinning of HIV and TB services, which would improve retention in care. Currently there is non-integration of services (not specific to MSM). Referral of patients between services negatively affects retention in care.

Legal frameworks and human rights

» There is currently not enough focus on MSM.

» Documenting violation of rights is important e.g. challenges in rights to access treatment.

» MSM don’t know their rights and finding ways to inform them is difficult. Intimate partner violence is one example. How do they make the legal framework work for
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them? Need to educate MSM, communities, and health providers. How easy is it for MSM to access help and advice? Although the legal framework is in place, stigma and discrimination still exist.

» The upcoming national Key Populations Guideline document will increase knowledge of this issue.

» The national DOH is currently addressing prevention strategy, which is open to influence, and development. Could strengthen input into the implementation plan to increase MSM-directed prevention services.

» Discussion of how to improve access within state facilities – if train one clinician or champion, don’t change the culture of the organisation if that person leaves or is sick etc. Facility competency rather than one-person competency. This includes health issues and other issues such as legal, reporting violence etc.

» Should include legal framework education about key populations in Nurse initiated Antiretroviral Treatment training, medical and nursing school curricula – advocacy issue.

Access to education and labour

» Bill of rights guarantees access to education and labour for all in South Africa!

» Consider things like paternity leave for MSM parents, equivalent to heterosexual women who adopt a child – 4 months of leave rather than 3 days.

» Enforcement of non-discriminating workplace policy. Methods of how to educate about SOGI in workplace and how to document violations.

» Lack of workplace rights and compromising economic status because of MSM behaviour might increase vulnerability to HIV.

» Ensuring that working environments help to improve quality of life, less stress, better mental health, less risk taking.

Homophobia and discrimination

» Identity matters, homophobia implies prejudice against an orientation rather than behaviour. Links back to need for more evidence of the effect of identity and not just behaviour.

» Further sensitivity training about heteronormativity of institutions such as police services.

» Everyone should be able to be who he or she is without prejudice.

» More effort must go into training those who disseminate information about MSM, rights etc. to ensure uniformity of messaging despite working at different levels.
Community organising

» Most work is at provincial or national level rather than at community level. This can be addressed with outreach.

» Outreach can raise awareness in MSM communities.

» Using media such as TV: but these need to be informed messages and hopefully change health-seeking behaviour or risk behaviour.

» Does public messaging compromise MSM – for example much of public discourse involves bisexual men rather than exclusive MSM. Media tools need to be better informed and engage MSM communities better.

» Concern that media perpetuates certain negative aspects of MSM stereotypes but positive media should be encouraged.

Question 2: What is possible now?

» Condoms and lubrication distribution is non-negotiable.

» HCT – expanded to the right areas.

» Understand treatment and treatment challenges better e.g. adherence, linkage to care, primary resistance rate monitoring.

» All facilities which deliver HIV / ART service should be trained to deliver competent care to MSM (and other populations e.g. youth).

» Include more specific gender training in health care worker curricula.

Question 3: Role of actors in strengthening the response?

» Understand funding landscape from different funders.

MSM organisations

» Advocacy and ensuring access and input into all levels of programming and planning.

» Bridge between government and MSM in communities.

» Evidence-based interventions.

Government

» Ensure an enabling environment.

» Gatekeeper role in implementation.

» Ensure domestic funding for programmes. Need priority funding.

» Partner with knowledge-experts.
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International organizations

» Role of WHO is to provide normative guidance:
   – Issues around evidence, sharing lessons from other countries.
   – Conduit between countries, linkage or network of countries.
   – To facilitate multilateral information sharing and integrated responses.
   – To influence government plans and encourage civil society to hold government accountable.

» Other donors:
   – Need to continue funding until domestic resources are available, long term funding.
   – Expand the funding base for MSM work.
   – Ensure that funding is directed where need is greatest.

» Recipients of donor funding have a responsibility to ensure good alignment between funding allocation and need i.e. don’t accept funding if donor priority is not in line with need.

Lesotho feedback

Question 1 – What is needed in relation to aspects or programming?

Evidence

» A study to help understand the size of key populations in the country (MSM and Sex workers) is planned – USAID and GF and government funded.

Prevention services, care and treatment

» Sensitisation for communities and health care workers.
» Use of existing voluntary medical male circumcision (VMMC) clinics as entry points to comprehensive prevention services centres, e.g. offer condoms and lubricants, do STI screening and treatment.
» Scale up condom distribution and lubricants.
» Resuscitate Key Populations TWG/Task teams and engage them in planning and implementation.
» Strengthen capacity building for health care workers to provide competent sexual health services, including re-orientation and strengthening of the Ministry of Health Sexual and Reproductive Health unit to improve general health services for men.
The Lesotho government and UN agencies have worked together to recreate task teams—working groups to plan and implement activities that concern key populations.

**Legal frameworks and human rights**

- Improve documentation of good and bad practices related to MSM and other key populations' health issues to use for advocacy.
- Use available evidence to influence relevant policy changes.
- Need evidence to support argument and point out existing gaps for service delivery for MSM and other key populations.
- Legal institutions for all levels of care need to come together: committee to work at national level to advice on legal frameworks hindering progress for MSMs and other key populations.
- Link and create networks of local legal institutions at all levels to act as a legal advisory bodies and advocates, and discussion platforms for these issues.

**Homophobia and discrimination**

- Review the LGBTI strategic plan together with the national strategic plan in order to align the two.
- Disseminate and coordinate the implementation of the two strategies (which include activities meant to address ignorance, discrimination, homophobia, and advocacy issues).
- Monitor and evaluate the implementation of the strategic plans.
- Design and develop IEC material and aids to educate the general public.

**Question 2: What is possible now?**

- Social mobilisation and community outreaches for men’s health.
- Use of ambassadors and peer educators at community level to create linkages at all levels.
- Formation of community support groups.
- Build the capacity of community based organizations already affiliated with men issues to include MSM issues.
- Need to put in place structures that move from community level to national level and communicate with one another.
- Build capacity of implementers to develop good practices and influence change.

**Question 3: Role of actors in strengthening the response?**
Session six

» UN representatives will report and sensitise joint UN group.
» Minister of Health should brief and sensitise MPs, management and relevant departments
» MATRIX- use the International Anti-homophobia day to brief all members.

Mozambique feedback

Question 1 – What is needed in relation to aspects or programming?

Evidence
» The Mozambique Integrated Behavioural Surveillance Survey (IBSS) needs to be finalised and findings disseminated.
» There is a need to expand the research to other provinces (only done so far in three of the eleven provinces).

Prevention services
» Find out about the possibility extension of community testing including using MSM peers.
» Increase health services for men, including awareness to improve on men’s participation in health services – sensitisation and awareness needed.

Care and treatment
» Update the national treatment guide to accommodate diseases relating to MSM.
» Ensure inclusion of MSM in latest HIV Acceleration Plan.

Legal frameworks and human rights
» MSM is not a crime in Mozambique.
» Advocacy for legal registration of community-based MSM organizations.

Access to education and labour
» This is not a problem in Mozambique.

Homophobia and discrimination
» Community sensitising and education on discrimination of MSM (Including leaders) needed.

Community organising
» Financial and technical support
Session six

Question 2: What is possible now?

» Inclusion in HIV Acceleration Plan.
» Update treatment guide to accommodate diseases related to MSM.
» Finalise the dissemination of the IBSS – report has been done and shared with some organisations – official publication to follow.
» Increase health services for men including awareness to improve men’s part in health services/advocate for legal registration of community bases MSM organisations.

Question 3: Role of actors in strengthening the response?

GF and PEPFAR

» A meeting between GF and PEPFAR to establish the baseline in terms of financing.

UN and other donors

» Technical support on suitable service packages.

CCM

» Inclusion of MSM working group representatives in CCM.

National and sub-national governments

» Increasing health services for men including awareness to improve on men’s participation in health services.
» Strengthen M&E.

Minister of Health will share information on importance of including MSM in National AIDS plan. GF Recipient will brief meeting and sensitize on possibility of working with MSM organisations. MSM organisations will inform other group members about the meeting and follow up.

Kenya feedback

Question 1 – What is needed in relation to aspects or programming?

Evidence: Epidemiology and Social Science

» Contribute to the finalization of size estimates (triangulation and consensus) – Provide Programmatic Data to support the working consensus estimates being used in the country.
» Strengthen the Monitoring & Evaluation and Routine Data Quality Assurance – develop tools, visits, documentation and the right people to do the work.
» Documentation and alignment with national database.
Session six

**Legal Framework and Human Rights**

- Network with Human Rights organisations for advice, legal representation, and advocacy.
- Support policy, advocacy, and legal interventions in country to facilitate dialogue with policy makers for the implementation of MSM programmes.
- Training and sensitisation of MSM to know their rights and to reduce self-stigma.

**Prevention Care and Treatment**

- Continue to provide: Minimum package of services to MSM – Country and WHO standards of care of care and treatment.
- HIV counselling and testing, peer education, outreach, distribution of condoms and lubricants and formation of support groups.
- Develop appropriate information, Education and Communication materials for MSM.
- Provide service delivery points outside of health facilities to provide alternative/complimentary access to services to MSM.

**Question 3: Role of actors in strengthening the response?**

**GF**

- Flexibility for resource support and participation of MSM in their own interventions.
- Pre-Financing to strengthen capacity of MSM to access resources and participate in country dialogues and other strategic level.
- Influence country players for inclusion of MSM in country mechanism; support for strengthening community systems.
- Support NSP at country level.

**Donors, UN and other International Organization**

- Capacity strengthening support. Collaborative interventions to avoid duplication and enhance complimentary service provision to avoid gaps.
- Support for tools and systems strengthening.
- Advocacy and networking support.

**MSM Organisations**

- Community organisations to identify needs and secure support.
- Strengthen systems and process as well as basic governance and management to ensure accountability frameworks are in place.
Session six

» Come up with innovative interventions to reach hidden populations.
» Documentation and institutionalization of best practices for evidence-based programming.
» Document grass roots practices.
» Networking and advocacy.

Namibia feedback

Question 1 – What is needed in relation to aspects or programming?

Evidence

» Epidemiological evidence:
  - Integrated Behavioural Biomedical Surveillance Survey (IBBSS): Epidemiological data collection tool/ Periodic research done in country, using biomarkers and integrating behavioural aspects. Hoping for MSM data to come out of this.
» Root cause analysis critical:
  - Research or papers commissioned on social theory. Promotes understanding of the legal context and social theory around ‘citizenship/ nationhood’ as well as geo-political comparisons e.g. Safe spaces/ power relations/ post-colonial theory vs. Sexual Orientation and Gender Identities– interrogating the “un-Africaness” of homosexuality/homophobia.
  - Impact of socio-economic conditions as contributing factors to the MSM/ transgender discourse (wider LGBTIQ).
  - Body politics research (looking into violence).

Prevention services

» Prevention has been done in the country, but can be improved as not wide reaching enough, since MSM/ Transgender communities are not visible.
» Research to target Transgender communities.
» Baseline research/ surveys on the tools that this target market uses (e.g. Injecting hormones, silicone, and the extent of transmission because of needle sharing/ drug interaction.)
» MSM who are in heterosexual settings.
» Young MSM who are of school going age (issues of requisite parental consent, confidentiality).
» Lack of lubrication in the country (currently being donated by USAID).
Session six

» Advocacy to procure lubrication through the Central Medical Stores as part of prevention commodities.

Care and treatment

» Weak linkage to treatment and care.

» Referral collection boxes have been placed in the health care facilities, but it is still difficult to determine whether MSM referred for care receive the services and continue to access services, or whether or not they are part of adherence support groups.

» Lack of a proper health care referral system: Need for bi-directional referral systems.

» Health care worker competence to provide efficient services.

» Sensitisation is critical, but we need strong curricula to train.

» Health care professionals: In-service training curricula exist, but the need for pre-service training is critical, at University/ Nurse college levels - no good models in Africa.

» Psychosocial support: mainly community based at facilities, palliative care, because of criminalisation/ rejection/marginalisation; self-stigma).

Legal frameworks and human rights

» Constitutionally, everyone has access to legal aid in the country.

» We need to strengthen of the provision of legal aid services/ legal advise at organisational level

» Criminalisation: Best avenue to see how best to decriminalise sex between men (this is specifically criminalised), as this is justification for stigma and violence. Ask Parliament to repeal the law or abolish it (esp. sodomy).

» Advocate for policy reform (to promote human-rights based approaches).

Access to education and labour

» Looking at other sectors (outside of HIV) to look at developmental/ human rights issues affecting MSM/ transgender within their sector mandates (E.g. Ministry of Education looking into issues of bullying/ at schools by virtue of gender non-conformity).

» Communities (MSM/ transgender) need “KNOW AND CLAIM YOUR RIGHTS” campaigns.

» Broader community education and sensitisation, especially at traditional authority level (e.g. What happens with a transgender person/ MSM when they appear in customary courts?).
Session six

Homophobia and discrimination

- Violence, hate crimes perpetuating stigma – Research into the extent of the problem.
- Advocacy with religious and traditional authorities to reduce the levels of stigma and discrimination at community level.
- Fostering of family values/ dynamics.

Community organising

- Defining what community systems strengthening means within our context (to encourage community participatory approaches to MSM issues).
- Community systems strengthening (Civil Society Support) through regional organisations applying for GF funds.
- Advocate at Board level.

Question 2: What is possible now?

- Review of the National Strategic Framework in May – Key entry point to position MSM issues.
- Reform structures such as CCM and NAC ensuring meaningful MSM/ Transgender representation.
- Sub-recipients selection: could include MSM organisations such as Out Right Namibia.
- Engaging of the broader public through strategic events such as IDAHOT (17th May), where the first LGBTI Human Rights Report will be launched – entry point that will be supported through activities planned for 13th to 17th May 2013.
- Health systems strengthening by consolidating the existing health information systems in the country – In the GF proposal.
- Streamlining information systems in the community. E.g. Utilising a ‘Unique identifier’ for clients.

Question 3: Role of actors in strengthening the response?

- Community systems strengthening (CSS) through regional organisations applying for GF funds. Advocate at Board level.
- Donor dialogues to assess and strategise how to ensure funds trickle down to organisations that need them (community-based organisations) – Making funding more accessible for grassroots MSM organisations.
- MSM organisations must have discussions with Donors on ‘aid conditionality’ to ensure that we do not become ‘collateral damage’ in our respective contexts – move away from current rhetoric.
- UN agencies should continue to engage government strategically to encourage
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rights-based programming/ Create spaces where they can bring together relevant stakeholders to start dialogues around legal and policy barriers to effective programming.

» Network bodies such as NANASO, NANGOF to produce fact sheets on MSM, Human Rights, to create in-country dialogues – well positioned to bring together civil society actors.

» MSM-led organisations to ensure capacity building of mainstream HIV organisations.

» International organisations providing technical support to local and grass roots MSM-led organisations, to build their capacity.

» Media education and sensitisation on ethical reporting of MSM and transgender issues.
Session seven

WHO and Global Fund representatives led the closing discussion with the group. The consensus was that the meeting had been very productive in raising awareness on the possible avenues for reprogramming of Global Fund grants to encompass MSM targeted activities. The country participants had started important dialogue, which will continue in country, and which will hopefully help lead to appropriate programme design and funding applications.

Additional discussion points were:

Participants were urged to:

» Commit to participating in their Country Coordinating Mechanism meetings, to ensure that MSM are on the agenda and follow up on the implementation of recommendations from this meeting.

» Consider what they could do as individuals? This may include communication with MSM organisations, writing to ministers of health, other activities.

» Ensure the involvement of the people who will benefit from the programmes at every stage.

» Advocate for registration of MSM organisations in country.

» Produce information for and about communities.
Session seven

» Use the grant tools at their disposal. The CCM is first point of entry in country, as – they apply for funding from the GF.

» Consider at a local level how to include MSM and transgender in the mainstream organisations. Globally the two populations are quite distinct. MSM organisations are often perceived as marginalising Trans women, who increasingly want to be seen as a specific population group. National Strategic Plans should enable the transgender community to achieve adequate and appropriate responses.

» Consider how to coordinate across services (possibly with unique identifier codes): key populations are seeing different health care providers and organisations, and it is difficult to trace and track service provision.

Additional discussion points were:

» The new GF funding model is in place, but still needs to be understood more widely. Participants were urged to do as much as they could to understand the model and take advantage of entry points and get involved.

» Research and information gathering, including IBBSS surveys are happening in the region. These provide good building blocks for information, providing baselines about MSM to implement evidence-based interventions. However much more baseline research is needed.

» It is important to map donor landscape in these countries. In most countries GF and PEPFAR are largest funders for prevention and treatment programs.

» Additional information on any potential risks of lubrication must be disseminated as it becomes available.

» A more holistic “Men's health” angle to enable service implementation may be a useful approach.

» Ambassadors from MSM networks can bridge gaps between communities and services.

» There is a need to increase community level programming and identify different ways of channelling Community Systems Strengthening information. There is a clear momentum for key populations in Africa, and much is possible now and in future. Need to co-ordinate and take advantage of finance and support available.

» Regional proposals may be very important – perfect for Human Rights programming and community strengthening.

» This meeting is building on what everybody is trying to create in the region – trying to meet targets – reduce infections, keep people alive and remove discrimination. Even without funding and with legal obstacles, an impressive amount of work is already happening. How much more could happen if technical and financial support was available?

The WHO and GF noted their appreciation of the participation at the meeting and hoped
that the dialogue will continue at country level. It was noted that meeting presentations and reports would be shared with participants.

This two-day conference should be seen as the beginning of a process that will result in better prevention and care services for MSM in the region.
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Appendix one

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Switzerland  
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# Meeting Agenda

## Day one:

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>09:00 - 09:30</td>
<td><strong>Opening ceremony</strong></td>
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<td></td>
<td>Opening ceremony</td>
<td>Steve Letsike, Vice Chair, South African National AIDS Council</td>
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<td></td>
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<td>Mauro Guarinieri, GFATM</td>
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<td>Sarah L. Barber, WHO Representative SA</td>
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<td></td>
<td>Logistics and security briefing</td>
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<tr>
<td>09:30 - 10:30</td>
<td><strong>Session one - Introduction/background</strong></td>
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<tr>
<td>09:30 – 09:50</td>
<td>The Magnitude of the HIV epidemic involving MSM and other key populations in the region</td>
<td>Frank Lule - WHO, AFRO</td>
</tr>
<tr>
<td>09:50 - 10:10</td>
<td>Clinical Priorities in the Response to HIV in MSM in Developing Nations</td>
<td>Kevin Rebe - Health4Men, Anova Health Institute</td>
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<tr>
<td>10:10 - 10:30</td>
<td>Financing the response to HIV among MSM in Southern Africa</td>
<td>Owen Ryan - AMFAR</td>
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<tr>
<td>10:30 – 11:00</td>
<td>Break</td>
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<tr>
<td>11:00 – 12:00</td>
<td><strong>Session two - Current response and challenges in addressing HIV among MSM in SSA</strong></td>
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<tr>
<td>11:00 – 11:30</td>
<td>Social/Structural Predictors of Access to HIV Services among African MSM: Implications for Program Design and Delivery</td>
<td>George Ayala MSMGF</td>
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<tr>
<td>11.30 – 11.45</td>
<td>Key barriers to effective programming for MSM</td>
<td>James McIntyre</td>
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<tr>
<td>11.45 – 12.00</td>
<td>Enabling environments: a human rights approach to HIV prevention among MSM</td>
<td>Joel Nana AMSHER</td>
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<tr>
<td>12:00 – 13:00</td>
<td>Lunch</td>
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### Appendix two

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>13:00 - 17:00</td>
<td><strong>Session three - HIV Prevention and Treatment for MSM</strong></td>
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<tr>
<td>13:00 - 13:45</td>
<td><strong>WHO Guidance on Prevention and Treatment of HIV for MSM</strong></td>
<td>Annette Verster</td>
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<td>» Implementation of comprehensive package of integrated services for MSM</td>
<td>WHO</td>
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<tr>
<td>13.45 - 14.45</td>
<td><strong>Panel session: Programme Examples 1 - Services and training</strong></td>
<td>Panel</td>
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<td></td>
<td>» Ways of working in ‘difficult’ environments: Addressing stigma and</td>
<td>Chairperson: Alasdair Reid, UNAIDS</td>
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<td></td>
<td>discrimination to improve service delivery</td>
<td>Malawi: David Kamkwamba, JONEHA</td>
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<td></td>
<td>» Including mix of services offered in current programmes</td>
<td>Kenya: George Githuka, NASCOP</td>
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<td></td>
<td>» Service delivery issues, outreach, training of staff, links with other</td>
<td>South Africa: Glenn De Swardt, Health4Men</td>
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<td>services</td>
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<tr>
<td>14:45 – 15:00</td>
<td><strong>Break</strong></td>
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<tr>
<td>15:00 - 16:00</td>
<td><strong>Panel session: Programme Examples 2 - Prevention and testing</strong></td>
<td>Panel</td>
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<td>» Intervention strategies: Condoms, innovations for an old solution</td>
<td>Chairperson: Amitrajit Saha, UNDP</td>
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<tr>
<td></td>
<td>» Intervention strategies: HIV testing and counselling and linkage</td>
<td>Kenya: Peter Njane</td>
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<td></td>
<td>to HIV care and ART</td>
<td>Malawi: Gift Trapence, CDEP</td>
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<td>Mozambique: Danilo Da Silva</td>
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</tbody>
</table>
### Panel session: Programme Examples 3 - Intervention strategies:

- STI prevention, screening and treatment
- Access to care and treatment
- Linkage to care and evaluation
- Emerging interventions and State of the Art

### Panel

- **Chairperson:** George Ayala, MSMGF
- **South Africa:** Jacques Livingston
- **Lesotho:** Lineo Mothopeng, Matrix
- **Namibia:** Friedel Dausab

### Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>16:00 - 17:00</td>
<td>(10 minutes per presentation 30 minutes for discussion)</td>
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<tr>
<td>17:00 – 19:00</td>
<td>Reception</td>
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## Appendix two

### Day two:

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>08:30 – 09:00</td>
<td><strong>Session four - Objectives for Day 2</strong></td>
<td>Frank Lule - WHO, AFRO</td>
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<tr>
<td>08:30 – 09:00</td>
<td>Synthesis of Day 1</td>
<td>Frank Lule - WHO, AFRO</td>
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<td>Objectives of Day 2</td>
<td>Frank Lule - WHO, AFRO</td>
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<tr>
<td>09:00 – 09:30</td>
<td><strong>Session five - Update on new GF funding mechanism</strong></td>
<td>Group work</td>
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<tr>
<td>09:00 – 09:30</td>
<td>Update on new GF funding mechanism: MSM-focused projects and proposals that could be included in GFATM proposals</td>
<td>Group work</td>
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<tr>
<td>09:30 – 09:45</td>
<td>Break</td>
<td>Group work</td>
</tr>
<tr>
<td>09:45 – 12:00</td>
<td><strong>Session five - Group work one</strong></td>
<td>Group work</td>
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<tr>
<td>09:45 – 10:00</td>
<td>Introduction to Group work</td>
<td>Carlos Caceres - Cayetano Heredia University International AIDS Society</td>
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<tr>
<td>10:00 – 10:30</td>
<td><strong>Group work one</strong></td>
<td>Group work</td>
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<td>» Provide evidence to adjust/adapt present recommendations for the countries in the sub-region</td>
<td>Group work</td>
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<td>» Training for health workers - review existing projects and programmes and additional needs</td>
<td>Group work</td>
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<tr>
<td>10:30 – 12:00</td>
<td>Feedback from group work</td>
<td>Facilitator: James McIntyre, Anova</td>
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<tr>
<td>12:00 – 13:00</td>
<td>Lunch and Group Photo</td>
<td>Group work</td>
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### Session six - Group work two

| 13:00 – 14:00 | Group work two | Group work
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<tbody>
<tr>
<td></td>
<td>Ways of dealing with stigma/hidden MSM populations and identifying ways to reach them</td>
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<td>Identify and plan for documentation of ‘good’ MSM programmes and practice (community based, outreach, health services and describe links between community programmes and health sector)</td>
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| 14:00 – 15:00 | Feedback from group work | Facilitator: Frank Lule, WHO |
| 15:00 – 15:15 | Break | |

### Session seven - Plenary discussion

<table>
<thead>
<tr>
<th>15:15 – 16:15</th>
<th>Plenary discussion</th>
<th>Plenary discussion</th>
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<td>Consider opportunities for piloting implementation of the MSM guidelines (plus additional combination prevention elements??)</td>
<td>Facilitator: Mauro Guarinieri, GF</td>
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<td>Opportunities for south-south sharing and learning</td>
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<td></td>
<td>Advocacy needs and tools</td>
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| 16:15 – 17:15 | Closing session: Next Steps | Frank Lule, WHO Annette Verster, WHO Mauro Guarinieri, GF |