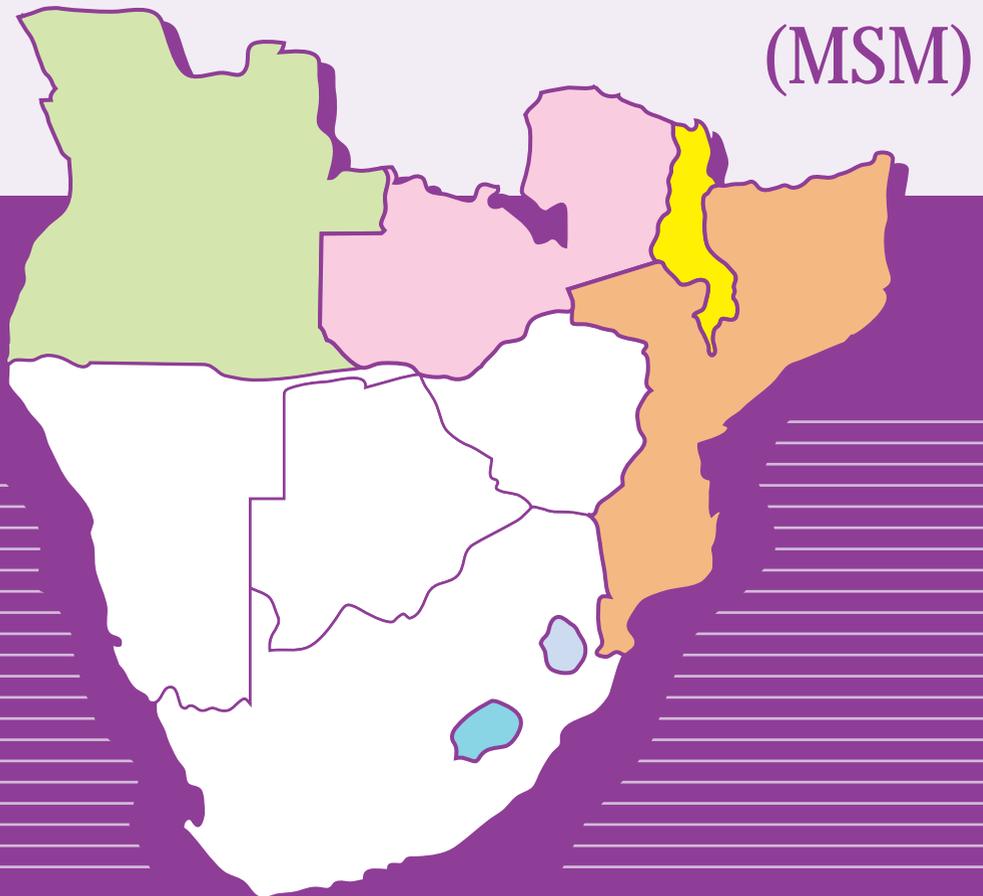


# Challenges Facing HIV Prevention for Men who have Sex with Men



Angola, Lesotho, Malawi,  
Mozambique, Swaziland and Zambia

# Challenges Facing HIV Prevention for Men who have Sex with Men (MSM)

Angola, Lesotho, Malawi,  
Mozambique, Swaziland and Zambia



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## LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ARASA	AIDS and Rights Alliance of Southern Africa
ART	Antiretroviral Therapy
CDC	Centres for Disease Control and Prevention
GBV	Gender Based Violence
GIPA	Greater Involvement of People Living with AIDS
HIV	Human Immunodeficiency Virus
IRIN	Integrated Regional Information Network
LGBT	Lesbian, Gay, Bi sexual and Transgender
MARP	Most AT Risk Population
MSM	Men who have Sex with Men
MSMGF	Global Forum on MSM and HIV
NGO	Non-Governmental Organization
OSISA	Open Society Initiative of Southern Africa
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Fund for AIDS Relief
PRISM	Prevention and Research Initiative for Sexual Minorities
PSAf	Panos Institute Southern Africa
PSI	Population Services International
STI	Sexually Transmitted Infection
SOGI	Sexual Orientation and Gender identity
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

## DEFINITION OF TERMS

Bisexual:	A man who is sexually attracted to both men and women.
Coming out:	Telling other people about one's sexual orientation i.e. that one is gay, lesbian or bisexual.
Gay:	A man who is sexually attracted to other men.
Heterosexual:	A man who is sexually attracted to women.
Homophobia:	The disapproval, fear or hatred of homosexual people
Homosexual:	A man or woman who is sexually, emotionally, spiritually and physical attracted to someone of the same sex .
In the closet:	Telling no one that one is a man who is homosexual/gay or that you have sexual feelings for people of the same sex with you.
Lesbian	A woman who is sexually attracted to other women
Penetrative sex:	Sexual activity that involves penetrating usually with a penis. This can be oral, anal or vaginal penetration.
Safer sex:	Having sexual intercourse that uses methods of reducing the risk of transmitting or contracting HIV or other STIs. Most common way is using a condom.
Sexual orientation:	The biological sex to which a particular person is attracted. For example, a man who is attracted to both women and men is bisexual.
Sexuality:	A broad term covering sexual identity (e.g. whether you call yourself 'gay' or 'straight'), sexual orientation (i.e. who they are attracted to), sexual behavior (e.g. some may describe themselves as 'gay' but be bisexual in their behavior), and sexual preferences (e.g. with older or younger people).
Heteronormativity:	This is a term used for a situation when a system of norms, institutions and structures naturalize heterosexuality as universally and morally righteous.

# SECTION 1:

## GENERAL INTRODUCTION

## 1.1 Introduction

In America, HIV first emerged among populations of Men who have sex with Men. More than a quarter of a century later, this trend continues to be seen in the high incidence of infections in many countries, including those in the SADC region. Male-to-male sexual intercourse remains one of the major ways through which HIV is transmitted. Men who have sex with men (MSM) is a technical phrase intended to be less stigmatizing compared to terms such as gay, bisexual, or homosexual. It describes sexual relations between men rather than identities, orientations, or cultural categories. Therefore, the term MSM includes gay men, bisexuals, and any other men who may not identify themselves as gay or bisexual but have sexual relations with other men. Men belonging to these diverse populations may have both individual and network-level risks and varying HIV epidemic dynamics<sup>1</sup>.

Many MSM also report having sex with women. Consequently, preventing transmission among MSM will not only combat the epidemic within this group but also within society as a whole<sup>2</sup>. However, state criminalisation, society stigma, and a culture of secrecy and silence among MSM, prevent research and the creation of strategic interventions to deal with the nature and magnitude of the problem in most African countries.

In spite of the existing evidence that the HIV epidemic continues to grow among MSM populations, and that HIV infection among MSM contributes significantly to the generalised epidemic (through bisexual relations), few countries have taken active steps to reverse this crisis. In the SADC region, HIV/AIDS programmes targeted at MSM are generally low in numbers in the HIV/AIDS programming. Ironically, Southern Africa is the most affected by HIV and AIDS in the world. While unprotected heterosexual sex is responsible for the largest number of HIV infections in sub-Saharan Africa, there is growing evidence of high rates of HIV transmission among MSM and from MSM community to the general population in the region<sup>3</sup>.

However, HIV/AIDS service provision and access for MSM remains low in most countries in Southern Africa. In many countries, institutionalized homophobia and criminalization of homosexual activity facilitate the spread of HIV and this severely hinders efforts to provide reproductive health services for MSM. In Southern Africa, only South Africa recognises same sex relationships and provides legal protection. However, in other countries in the region there

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1 Stefan Baral, FrangiscosSifakis, Farley Cleghorn, Chris Beyrer The Epidemiology of HIV Among MSM in Low- and Middle-Income Countries: High Rates, Limited Responses, AMFAR Report 2008

2 USAID Policy Brief, September 2005.

3 UNGASS Report , Global overview , HIV and MSM, 2008

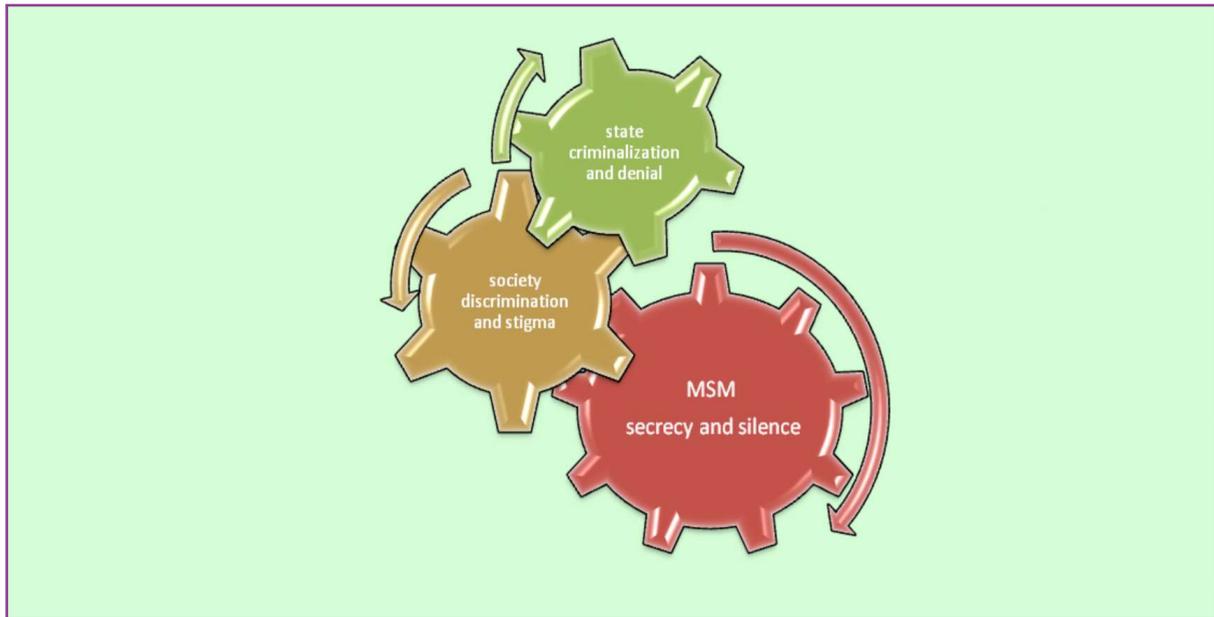
is lack of such recognition, although there is evidence of high prevalence of sex same sexual activity. This is, in most cases, invisible because of fear of prosecution and discrimination. Although the law is favourable in South Africa, the challenge with people's attitudes which are discriminatory and violent towards LGBTI people causing the LGBTIs to live a life of secrecy that is not identifiable.

## 1.2 Rationale for the study

The evidence base for newly emerging HIV epidemics among sexual minorities such as MSM is growing. This points to the need for urgent strategic prevention interventions and the creation of a more conducive environment access to services for minority groups is ensured, and health service provisions are readily available. In order to inform advocacy programmes, there is need to understand the underlying dynamics in most of the Southern African countries which do not have policies and a legal environment that is sufficiently conducive for undertaking initiatives for HIV prevention among MSM. In most cases, the magnitude of the problem of HIV infection among MSM is not fully appreciated.

The Universal Declaration of Human Rights (1948), as one of the international human rights laws, guarantees everyone the right to freedom of sex, sexual orientation and freedom from sex/gender identity discrimination. However, MSM are continuously discriminated and their rights violated. This situation has led to homosexual relationships being almost illegal, hidden and seen as taboo thus making MSM difficult to access sexual health care and services. As a result, MSM are ignored, forgotten or never engaged in HIV/AIDS and other reproductive health programming. Further, discrimination prevents MSM from disclosing their sexual orientation, or accessing and reporting for HIV services. Below is a diagrammatic illustration of the situation.

Figure 1: Criminalization, Stigma and MSM silence<sup>4</sup>



This study aims to identify gaps and challenges in MSM sexual and reproductive health policies and programmes in six Southern Africa countries. These are Angola, Lesotho, Malawi, Mozambique, Swaziland and Zambia. It will conclude by developing recommendations for policy advocacy and programming.

### 1.3 Study objectives

The objectives of this study are as follows:

- To highlight the magnitude of the problem of HIV infection among MSM and the spread of HIV/AIDS;
- To review current programmes targeting MSM in the six countries;
- To identify policy and programming gaps that need to be addressed for a better HIV/AIDS response for MSM in the six countries;
- To identify the role of the media in promoting HIV Prevention among MSM.

<sup>4</sup> Eduard Sanders - HIV epidemic among MSM in Africa - Centre for Geographical Medicine Research-Coast; Kenya Medical Research Institute; Kilifi, Kenya Nairobi 2008

## 1.4 Methodology

This was a desk research using documents review as the main methodology for data collection. It involved a review of existing documents on the subject matter, including the collecting and collation of data in line with the study objectives. Conclusions and recommendations were drawn based on the information collated around each objective. The major limitation of the study is that there was generally inadequate data on this subject in most of the countries under study not much research has been conducted on the subject.

## SECTION 2:

Challenges facing HIV and AIDS  
responses among MSM

## 2.1 Introduction

MSM face reproductive health challenges at two levels: challenges specific to MSM population as well as challenges affecting the broader society:

1. The barriers that prevent heterosexual individuals and communities from accessing quality HIV prevention care, support, and treatment services also apply to MSM. These include, among others, poverty where user fees are involved, geographically inaccessible services, negative service provider attitudes, unavailability of resources and being cultural factors.
2. Services specific for MSM reproductive health needs are almost non-existent. Due to the unfavourable legal and policy environment, there are no services that specifically target MSM. In additional health service providers are not trained in skills for managing MSM-specific needs. As a result, even when MSM do access health facilities, the service providers are not ready for them. The situation is further compounded by entrenched homophobia that is manifested in stigma and discrimination of all sexual minority groups including MSM. MSM also fear to come forth for services that are specific to them for fear of being found out and blackmailed.

Homophobia is institutionalized and even politicized as community leaders and heads of states openly condemn homosexuality. This makes it difficult for health service providers and potential programme beneficiaries of MSM initiatives to openly operate in a way that is officially recognised. South Africa is the only country in Southern Africa that has a constitution that clearly supports sexual minority people's rights. However, the situation is different on the ground as communities are not receptive of same sex relations. This creates challenges in implementing programmes for MSM.

There is need for making the environment friendly and enabling even after policy change is achieved. MSM interventions need to go beyond policy change and translate into effective programming.

The unfavourable legal environment undermines effective research to obtain baseline data that can inform programing. As a result, most countries do not have reliable data on the burden of the programme of the reach of the services.

The UNAIDS theme “Getting to Zero: Zero New Infections, Zero Discrimination and Zero AIDS Related Deaths” will remain an elusive dream for as long as these challenges remain.

The table below illustrates the legal status of same sex relations in all six countries as well as some of the neighbouring countries so as to contextualize the situation to the whole Southern Africa region.

Table 1.0 Position of laws on MSM in selected SADC countries

Country	Law on male to male relationship according to Constitution	Penal Code
Angola	Silent	Fines or restrictions or penal labour
Lesotho	Silent	Silent (Penal code 2010)
Malawi	Not Legal	Imprisonment of 10 years or more
Mozambique	silent	Silent
South Africa	Legal and Protected by SA Constitution	No
Swaziland	Not Legal	Imprisonment of less than 10 years
Zambia	Not Legal	Imprisonment of 10 years or more

Below is the discussion of the legal conditions in other countries.

### 2.1.1 Angola

In Angola, while the constitution is silent on same sex relationships, articles 70 and 71 of the Angolan Penal Code impose criminal sanctions on those who practice acts “against the order of nature”. In 2010, one of the legislators in Angola said, “In the light of the constitution, the family must be composed of men and women”. The MP said this while addressing a meeting with magistrates where he also stressed the need to preserve the traditional family structure as the fundamental core of the Angolan state and society.

### 2.1.2 Lesotho

The constitution of the Kingdom of Lesotho does not openly criminalise same sex relations between men. Nothing in the constitution explicitly provides for or prohibits homosexuality. As a result, the position of homosexuals as far as the constitution is concerned is a matter of inference. However, there is a Sexual Offences Act, that prohibits sodomy, or sex between men.

### 2.1.3 Malawi

In Malawi, the status of homosexuality is currently criminalized although there is a debate for reform. Currently, laws that discriminate against homosexuality were suspended. This has created an interim opportunity for effective programming. However, this is not adequate as it is just an interim or temporary solution. Under the laws that have been suspended, conviction for same sex relations attracts an imprisonment sentence of ten years or more.

### 2.1.4 Mozambique

In Mozambique, the law is silent on same sex relations because it does not explicitly forbid homosexuality or MSM activities. The law has descriptions like ‘vices’ against nature, which was interpreted as referring to bestiality rather than human sodomy so it does not criminalize homosexual activities. However, this situation does not protect MSM particularly from homophobic community leaders like church leaders and politicians.

### 2.1.5 Zambia

Homosexuality is illegal in Zambia, and one can be prosecuted and jailed for sodomy. The government continues to deny that homosexuals exist in the country. Politicians and church leaders debate and use gay rights issues for one to lose or gain political mileage while the underground situation makes MSM vulnerable to black mail and extortion. The Zambian Penal Code Act criminalises same-sex sexual activity for both men and women. According to Cap 87, sections 155 and 156, the Penal Code prohibits same sex relations and calls them “unnatural offenses.” In the new draft constitution, there is a recommendation against same sex relations under Article 47 (5) the recommendation is that marriage between people of the same sex is prohibited.

### 2.1.6 Swaziland

Same sex relations in Swaziland are both illegal and culturally frowned upon. Consequently, MSM are not open and programs to try and reach them are underground. This was confirmed in a study by D. Adams and other on MSM and sex workers in 2011. The study found out that, on the ground, MSM operate discretely for fear of arrest and stigma hence preferred to meet in private homes for any LGBTI related interventions<sup>5</sup>.

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<sup>5</sup> Adams, D, Mabuza, X, Mnisi, Z, Maziya, S, Fielding, R. & Kennedy, C. (2008), An iterative approach to respondent driven sampling (RDS) using community-based participatory research (CBPR) among men who have sex with men (MSM) and female sex workers (FSWs) in Swaziland, Johns Hopkins Bloomberg School of Public Health.

## 2.2 Rights Violations

In most of the countries under study, the rights of sexual minority groups are violated. Violations include hate speech that sometimes leads to hate crimes such as beatings, torture or even murder. These violations push MSM to the margins of society making them hard to reach with the necessary sexual health interventions. The result is that even where services could be available, MSM do not come forward to receive them. The other challenge is that even service providers are not prepared or trained to serve MSM and other sexual minority people. When MSM present themselves with specific problems like anal STIs or related infections, the reaction from the service providers is discouraging, (PSAf 2011 Mozambique MSM Oral Testimonies).

Below is a table with some of the rights and how they are violated.

Table 1.1 Examples of the Violation of Rights of MSM<sup>6</sup>

LGBTI Rights	How the rights are violated
The right to equality in rights and before the law	In many countries the LGBTI community is denied the right to equality before the law through special criminal provisions or practices on the basis of sexual orientation. The failure of many states to legally recognise the individual as the “right holder” with rights over control of their own lives and bodies could be interpreted as violating this right.
The right to non-discrimination	Denied by omitting sexual orientation or sex/gender identity in anti-discrimination laws, constitutional provisions or their enforcement.
The right to freedom from violence and harassment	Denied by omitting sexual orientation and sex/gender identity and gender expression in anti-discrimination laws, constitutional provisions or their enforcement.
Right to free development of one’s personality	Violated by the failure to recognise sexual difference and choice in all its forms and to develop legal protections for that diversity.
The right to life	Violated in states where the death penalty is applicable for sodomy. Denied by states which do nothing to curb a fear of difference that results in violence and death.
The right to be free from torture or cruel, inhuman or degrading treatment	Infringed upon by police practices in investigations or in the case of LGBTI persons in detention. Forced stripping of transgender people in detention is unfortunately all too common a form of torture.

<sup>6</sup> Protection International (2010) *Protection Manual For LGBTI Defenders*.

LGBTI Rights	How the rights are violated
The right to protection from arbitrary arrest and illegal detention	Occurs in a number of countries with individuals suspected of having a homo/bisexual identity. Detentions of dubious legal character are commonly carried out against transgender persons. Even where the law criminalises same-sex activity it can only be enforced if “caught in the act”. Arresting someone on the presumption of their sexuality is to all intent and purposes illegal.
The right to a fair trial	Often affected by the prejudices of judges and other law enforcement officials.
The right to privacy	Denied by the existence of ‘sodomy laws’ applicable to LGBTI persons even if the relation is in private between consenting adults.
The right to freedom of expression and freedom of association	Either denied explicitly by law, or LGBTI community may not enjoy them because of the homo/ transphobic climate in which they live.
The right to freedom of practice of religion	Usually restricted in the case of LGBTI persons, especially in the case of the clergy advocating against them.
The right to work	The most affected among the economic rights of LGBTI community, many LGBTI persons are fired because of their sexual orientation and sex/gender identity or discriminated in employment policies and practices.
The right to physical and mental health	Found to be in conflict with discriminatory policies and practices, some physicians’ homo/transphobia, the lack of adequate training for health care personnel regarding sexual orientation, transgender or intersex issues can negatively impact on this right.
The right to form a family	This is denied by governments by not recognising same-sex families and by denying the rights otherwise granted by the state to heterosexual families who have not sought legal recognition, but still enjoy several rights.
The right of protection against separation from parents	Children can also be denied this right based on a parent’s sexual orientation and/or sex/gender identity or gender expression.
The right to education	LGBTI students may not enjoy this right because of prejudices and violence created by peers or teachers in schools. The high rate of school drop-out amongst LGBTI youth is a direct consequence of bullying and discrimination.
The right to defend these rights	Violated by state’s failure to protect LGBTI defenders, repeal laws that are used to discriminate against LGBTI organisations and which prevent organisational activities from being carried out.

# SECTION 3:

## Current Policies and HIV/AIDS Programming for MSM in Southern Africa

### 3.1 Introduction

In Africa, protection to MSM is provided through the African Charter on Human and Peoples' Rights. This treaty was adopted by the Organisation of African Unity (now African Union) in 1981 and is the most widely accepted regional human rights instrument, having been ratified by more than fifty countries. It condemns discrimination and provides for certain rights, but so far, its monitoring and enforcing body - the African Commission on Human and Peoples' Rights - has not yet officially dealt with sexual orientation or sex/gender identity and gender expression cases.

### 3.2 Policies and strategies

There are international human rights instruments that guide member states and organizations on how to implement programmes that include or target MSM in HIV and AIDS responses.

### 3.3 World Health Organisation

In June 2011, WHO released 21 guidelines on management of STIs, HIV and AIDS among MSM. The guidelines address issues of human rights and non-discrimination in health-care settings, prevention of sexual transmission, HIV testing and counselling, behavioural interventions, information, education, communication; substance use and prevention of blood borne infections, HIV care and treatment, and on prevention and care of other sexually transmitted infections<sup>7</sup>.

### 3.4 The Global Fund

The Global Fund's Strategy for Sexual Orientation and Gender identity (SOGI) launched in 2012 also provides for inclusion of all people whose sexual orientation, gender identity and/or sexual behaviour are different from those of heterosexuals. This comprises men who have sex with men (MSM) and LGBTIs. Global Fund acknowledges that HIV/AIDS disproportionately impacts MSM, transgenders and sex workers. HIV prevalence among sex workers is higher than in the general population. Among MSM, both the incidence and prevalence of HIV/AIDS is high in all regions of the world, with recorded HIV prevalence rates as high as 25% in Africa, 11% in the Caribbean, 28% in Southeast Asia, and 51% in some parts of Latin America. Among transgendered persons, HIV prevalence is believed to be even higher than among MSM.

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<sup>7</sup> WHO, (2013), Guidelines for the prevention of HIV and STI among MSM and transgender people. [www.who.int](http://www.who.int)

Criminalisation of people due to their sexual orientation or gender identity negatively impacts their ability to access health services. In some countries on every continent, rights related to SOGI populations and access to health is still explicitly or implicitly denied through laws, religion, social institutions and cultural traditions. This includes hate speech by political leaders and religious leaders which normally culminates in physical violence against sexual minorities. Sex between consenting adults of the same sex is criminalized by approximately 85 countries, including 34 African countries, with 10 countries having death penalties for homosexual relations between consenting adults.

### 3.5 Commission on Sexual Orientation and Gender Identity (SOGI)

The SOGI Strategy acknowledges that MSM, transgenders and sex workers face serious challenges in accessing Global Fund grants. They face limited access to decision-making or control in CCMs, PRs and SRs, and there are many social and structural barriers to the realisation of health and rights for these populations. Around the world, even in countries where SOGI populations constitute nominal beneficiaries of Global Fund funding, there are consistent and extensive reports of funds not being allocated to appropriate interventions. There is also a severe lack of services related to health and rights, including a continued disregard for human rights. The strategy acknowledges that work in this area is difficult and sometimes controversial in many part of the world,” and that “there is no one approach for every situation.

### 3.6 UNAIDS

In August 2006, UNAIDS developed a policy brief on MSM that details the policy position of UNAIDS on the importance of MSM programmes. The brief outlines what action governments and civil society need to take at national and international levels. The policy recommends that governments take the following action:

- Empirically assess the role that sex between men is playing in the national HIV epidemic;
- Respect, protect and fulfil the rights of men who have sex with men;
- Prioritize strategies and budgets to address HIV prevention, care and treatment needs of men who have sex with men in national health and AIDS plans;
- Engage men who have sex with men, especially those living with HIV, in the design, implementation and monitoring of programmes as well as in National AIDS Councils;

- Tailor national, state and local HIV strategies for men having sex with men to epidemiological and social data;
- Promote programmes for men who have sex with men who may be especially vulnerable to HIV infection, such as sex workers, injecting drug users and those in settings such as military facilities and prisons where violence and sexual coercion may take place;
- Support non-governmental and community-based organizations, including organizations of people living with HIV, addressing issues related to sex between men.<sup>8</sup>

The brief made the following recommendations for the civil society organisations:

- To deliver programmes that promote access to HIV prevention, treatment and care for men who have sex with men;
- To challenge stigma and discrimination against men who have sex with men and advocate legal and policy reforms to promote their human rights and access to health services;
- To increase networking and information exchange with organizations working on behalf of men who have sex with men.

International partners were recommended to take the following action:

- Advocate government commitment to the actions outlined above and promote strategic alliances between civil society groups working on this issue including labour unions, employers, universities and other organizations;
- Provide funding for programmes that address the health needs and human rights of men who have sex with men, as well as support for civil society groups, especially those comprised of men who have sex with men;
- Support systematic surveillance of HIV infection occurring in the context of sex between men, particularly in low- and middle-income countries;
- Increase support for strategic information and research, including ethnographic research, to better understand the occurrence, contexts and risk behaviours associated with sex between men, including its implications for women partners;

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<sup>8</sup> UNAIDS (2006) Policy brief on MSM. [www.unaids.org](http://www.unaids.org)

- Ensure that international norms, standards and tools address the specific HIV needs of men who have sex with men.<sup>9</sup>

In response to these recommendations and guidelines from UNAIDS and WHO, international funders like USAID, World Bank, Aids Funds, HIVOS, PEPFAR, Sida Sweden, ILO and many others heeded the call and in turn came up with funding policies and guidelines for civil society and implementers to follow as they supported HIV/AIDS initiatives targeted at MSM. An example of this is the PEPFAR Technical Guidance on Combination HIV Prevention document that lists the core elements of MSM programmes as follows:

- Community-based outreach;
- Distribution of condoms and condom-compatible lubricants;
- HIV counselling and testing;
- Active linkage to health care and antiretroviral treatment (ART);
- Targeted information, education and communication (IEC); and
- Sexually transmitted infection (STI) prevention, screening and treatment

The document also provides guidance on how to optimize MSM initiatives by ensuring that the following are part of all programmes:

- Involvement and active participation of MSM;
- Ensure confidentiality;
- Provide staff training on how to handle MSM;
- Collect and use strategic information;
- Link, integrate and co-locate services for an efficient referral system;
- Incorporate research advances and new technologies.<sup>10</sup>

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<sup>9</sup> UNAIDS (2006) , Policy brief on MSM. [www.unaids.org](http://www.unaids.org)

<sup>10</sup> PEPFAR, (2011), Technical Guidance on Combination HIV Prevention; Source-published or online? Please indicate this.

### 3.7 Current HIV and AIDS Programming for MSM in the Southern Africa

In 2010, UNAIDS recommended MSM targeted responses to use Combination HIV Prevention. This is the tailoring and coordinating of Biomedical, Behavioural and Structural Strategies to reduce new HIV infections. This approach is recommended because it is rights-based, evidence-informed, and community-owned and uses a mix of biomedical, behavioural, and structural interventions. The approach is prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections especially among MSM<sup>11</sup>. Despite global and local evidence in Africa about the higher vulnerability of MSM to HIV infection, only a few African nations have attempted to put adequate responses in place. The responses have been through human rights defenders and coalitions that work to achieve the following:

- Strengthen capacity of national agencies and individuals working to improve policy, legislation and programming related to MSM sexual & reproductive health as well as increase the visibility of MSM issues across various levels such as policy, legislation, communities and service delivery.
- Render prevention, care and treatment services to MSM such as STI and HIV counseling and screening, condom and lube distribution, ART management i.e. monitoring adherence and prevention of opportunistic infections.
- Identify, advocate, and increase access for greater resources, including technical and financial, for better access to prevention, treatment and care services and facilitate the creation and dissemination of an evidence base for a better public health response on MSM issues.
- Advocate for the protection of gay men and other men who have sex with men from human rights violations.
- Render counseling and information to achieve behavior change among MSM.

One such coalition group is The African Men for Sexual Health and Rights (AMSHer) which is a regional coalition of MSM/LGBT led organizations and other organizations that work to address the vulnerability of gay and bisexual men, Male-to-female transgender women and

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<sup>11</sup> UNAIDS Combination HIV Prevention Discussion- September 2010.

other MSM, to HIV. AMSHeR is made up of 18 organizations from Burundi, Cameroon, Cote d'Ivoire, Ghana, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

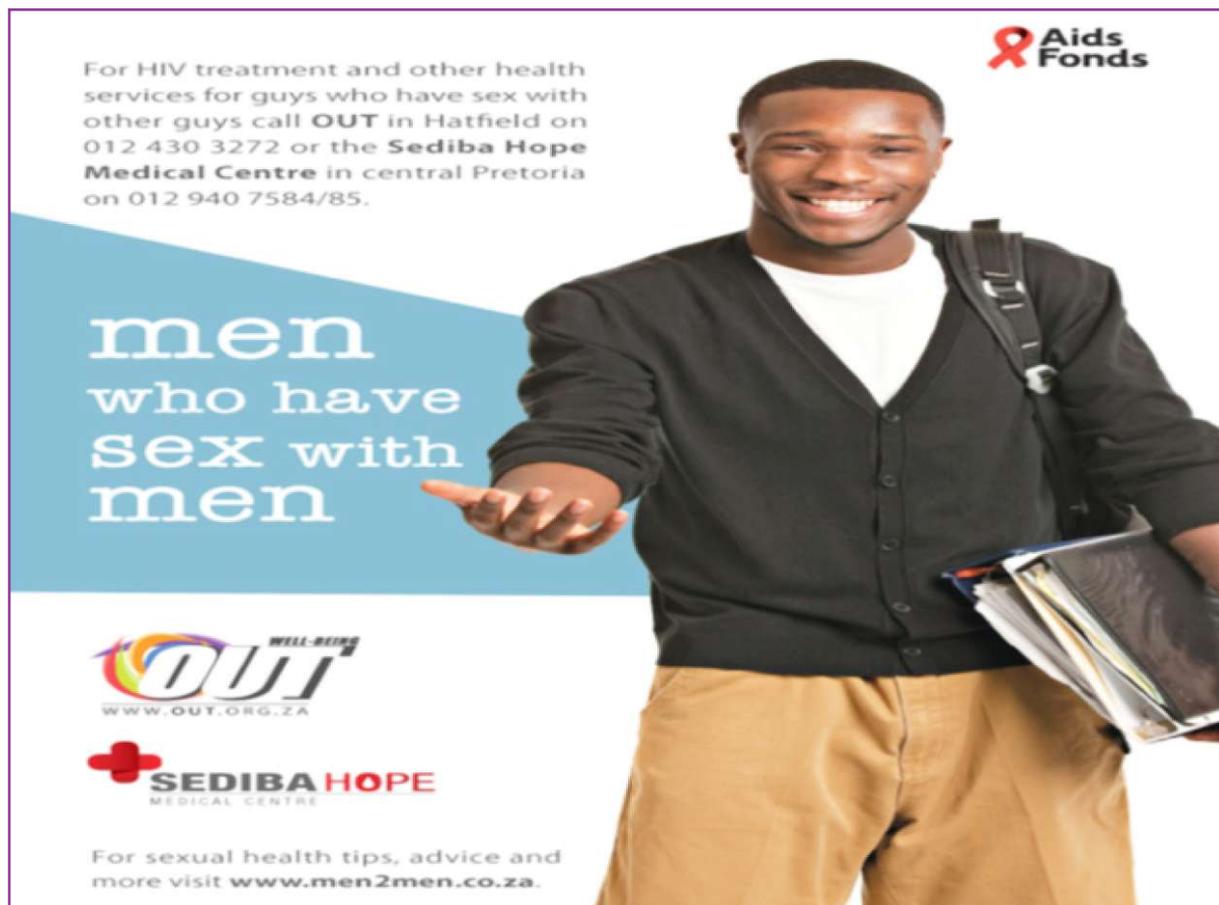
As a coalition of African-based and African-led MSM organizations, AMSHeR provides a platform for exchange and learning among grassroots MSM organizations, HIV services and advocacy organizations, human rights organizations and other agencies working with and/or for MSM communities. In addition to its work to bring about visibility and address MSM and HIV issues, AMSHeR advocates for greater resources for MSM work in Africa; it works to strengthen and develop community structures to address issues such as societal discrimination and stigma, and advocates for positive and inclusive policies and effective interventions. AMSHeR strives to increase the visibility of MSM issues across various levels such as policy, legislation, communities and service delivery, and strengthen capacities of national agencies and individuals working to improve policy, legislation and programming related to MSM sexual and reproductive health.

Other organizations that also support initiatives targeted at MSM in the region include COC Netherlands which focuses on programmes aimed at improving the capacity of LGBTI organisations to provide services and lobby for mainstreaming of services for such people. There is also Prevention and Research Initiative for Sexual Minorities (PRISM) and Proudly Combined, among others. There are other organisations whose core business is not MSM but contribute significantly to addressing issues of MSM and these include AIDS and Rights Alliance of Southern Africa (ARASA), Open Society Initiative of Southern Africa (OSISA), Southern Africa HIV and AIDS Information Dissemination Services (SAfAIDS), and Panos Institute Southern Africa (PSAf). South Africa has a number of organizations and clinics whose core business is supporting sexual minority groups. These include Health4Men, Out Wellbeing, The Triangle Group, Sediba Clinic among others. Although some of them are geographically based in South Africa, they have websites that have useful information for anyone looking for information on MSM. This makes their services not only confined to South Africa but rather accessible to anyone from anywhere in the world.

Other LGBTI organisations endeavour to promote biomedical prevention by increasing numbers of MSM reached for HIV prevention and treatment services. This is achieved through running HIV support groups as well as youth group meetings offering HIV testing and counselling services at gay venues as part of outreach work. Lubes are distributed at these gay venues. Because of criminalisation, services are mostly marketed by word of mouth. Some of the organisations like OUT, offer online question and answer services where questions are directed to Doctor Dick for male clients and to Doctor Delicious for female clients.

As part of the effort to integrate MSM interventions into mainstream HIV and AIDS initiatives, some organisations make posters with MSM messages and the posters are placed at health facilities and AIDS Service Organisations. The messages on posters are aimed at encouraging MSM to reduce the number of sexual partners and increasing MSM access to clinics, including sensitising the public on MSM issues. As the general public looks at and discusses the posters, dialogue on MSM is initiated and developed. Dialogue on MSM issues is needed for the development of necessary policy interventions. Use of ordinary looking men on the posters makes the public realise that anyone could be an MSM. It reinforces the idea that MSM are actually part of society. They are normal people and members of families. This, in the long run, can create a sense of social acceptance for them to be able to come out. As shown in Figure 2 on the following page, some of the posters have different messages and images that all MSM can identify with. For example, they have pictures young men, miners, uniformed forces, etc. They also use varying themes such as condoms and lube, PEP, sero-discordance and early treatment among others.

Figure 2: An example of one of the posters by OUT in South Africa



For HIV treatment and other health services for guys who have sex with other guys call **OUT** in Hatfield on 012 430 3272 or the **Sediba Hope Medical Centre** in central Pretoria on 012 940 7584/85.

**Aids Fonds**

men  
who have  
sex with  
men

**OUT** WELL-BEING  
WWW.OUT.ORG.ZA

**SEDIBA HOPE**  
MEDICAL CENTRE

For sexual health tips, advice and more visit [www.men2men.co.za](http://www.men2men.co.za).

Other MSM specific behavioural interventions ride on existing mainstream campaigns like the male circumcision campaign. One such an intervention for MSM had the following objectives:

- To increase the number of MSM who are circumcised and are aware of the measures that they need to take to practice safe sex for both their male and female partners
- To increase the number of MSM making use of regular VCT
- To create linkages and relationships with health care providers, and staff of AIDS Service Organisations (ASO) so as to improve the health seeking behaviour of MSM.

These approaches also address religious and cultural institutions because the public opinions are heavily influenced by these factors.

# SECTION 4:

## Observations and Conclusions

## 4.1 Introduction

The discussion on the two previous sections has raised a number of pertinent issues in relation to MSM and their rights as sexual minorities. A reflection on a number of key issues that have been highlighted, provides a number of important observations that can serve as conclusions that focus on major issues about MSM. These are as discussed below:

## 4.2 Legal and policy issues in each of the six countries

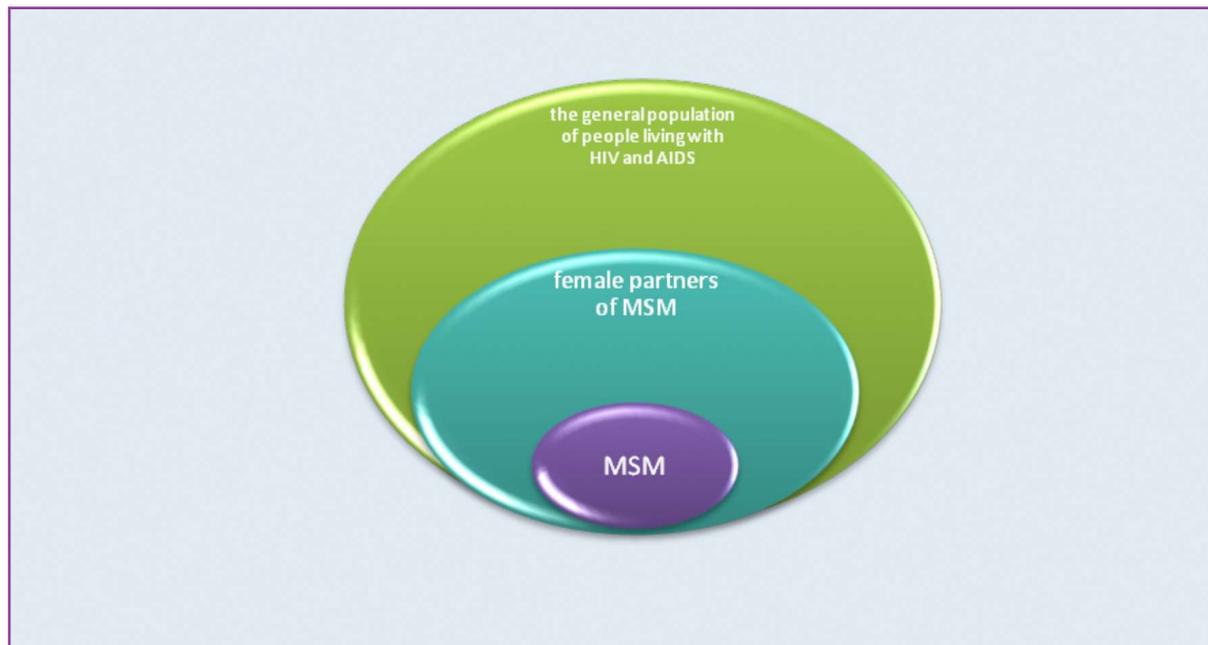
The study showed that same sex relations are not legal in all six countries. Even in countries like Lesotho, Angola and Mozambique where homosexuality is not outrightly criminalized, MSM are not protected by the laws in those countries. While the constitution may not mention homosexuality, or same sex relations, sodomy is mainly pointed out as illegal in all six countries. Societal attitudes tend to make something acceptable or not acceptable and this is influenced by religion and culture. Politicians and religious leaders tend to appropriate religion and culture to demonise MSM so as to render them social outcasts.

## 4.3 Significance of MSM issues in relation to the general response of HIV and AIDS

While under unfavourable legal, policy and social environments, it is difficult to find data and generate valid and accurate information based on empirical research on the magnitude of the health and social problems facing MSM. Consequently, HIV/AIDs in these countries continues to be a major problem that requires more research so as to create the much needed critical policy and strategic interventions. From a human rights perspective, it is important to address the challenges of MSM in the face of HIV/AIDS and other sexual and reproductive health issues regardless of how low the statistics are perceived to be. However, this is not the case in the six countries under study.

The documents that were examined for the study, such as the National Strategic Frameworks of all six countries, Modes of Transmission Analysis as well , and the reports by the Johns Hopkins School of Public Health, it is clear that governments of all six countries do not prioritise MSM HIV transmissions to be of any policy significance in relation to heterosexual modes of transmission. In their modes of transmission analysis, they found MSM to contribute small percentages as compared to multiple concurrent partnerships in heterosexual relationships. However, the document review of this study found that nearly 30% of MSM report having female sexual partners as well, this shows that the MSM epidemic is not isolated or separate from the mainstream general epidemic. The diagram on the following page attempts to illustrate the picture.

Figure 3: HIV transmission networks between MSM and heterosexual



#### 4.4 Current programmes targeting MSM

Implementers of MSM programmes include organisations that are sympathetic to LGBTI issues and human rights defenders. In all the six countries, MSM are mentioned in the National strategic Frameworks under special populations that are at high risk of HIV infection. However, not much seems to be done on the ground in mitigating the problem. Because of a homophobic operating environment as well as a disabling legal and policy environment, programmes targeted at MSM are limited.

In a fact finding mission involving about 25 groupings of LGBTI people in nine countries of Southern Africa, it was established that associations or activities of the groups happen discretely. With the exception of South Africa, Zimbabwe and Namibia, most associations take the form of house gatherings or small informal networks of friends, which are poorly organized and cannot sustain themselves. It is indeed nearly impossible for LGBTI groups to meet or organize because of restrictive or oppressive laws, official campaigns of intolerance, lack of information, negative media, deep cultural and religious disapproval, risk of social isolation, loss of livelihood and violence, absence of safe meeting places and lack of financial support. Consequently, the study showed that LGBTI people generally hold meetings and socialize only in homes than public spaces. In some cases, meetings are held in restaurants and in any

some organisations which are safe to MSM.<sup>12</sup> This scenario limits the kind of activities and formal programmes that can be done for and by MSM groups.

To confirm that not much is officially happening in the six countries, they all had no data to report on the five UNGASS indicators of MSM<sup>13</sup>.

Regional human rights defenders like OSISA have given institutional and programme support to some of the LGBTI groups. They have funded programmes where MSM receive information on sexuality, HIV prevention, positive living as well as safety and security tips in an environment that has rife blackmailing and extortion. Some programmes include psychosocial support to MSM as well as to family members where the MSM come out or are involuntarily exposed. Legal aid is offered in instances where MSM are arrested for being gay or for having committed crimes related to same sex relations in countries where homosexuality is criminalised. There are loose arrangements with specific doctors and clinics to offer health care services to members of LGBTI communities.

MATRIX, an organisation for LGBTI operating in Lesotho, was registered as a Non-profit organisation in Nov 2010 and in a way this allows or formally recognises that MSM activities are happening in Lesotho and the law recognises and acknowledges it. Being registered as an NGO means that MATRIX and its constituency can bring their activism to a higher level hoping to change the policy and legal environment where there is a law on sodomy. In the other five countries, attempts to have an LGBTI association registered are a programme activity. For years, LAMBDA in Mozambique has applied for registration to no avail but continues to informally support the membership which is mainly urban based. In Zambia, Friends of Rainka is a membership organisation that hopes to identify the needs and priorities of the LGBTI community. It also aims to research, gather, analyse and disseminate information on HIV and AIDS information. Other organisations such as Society for Family Health seem to have more formal programmes targeted at MSM or for the benefit of MSM.

In some instances, MSM are included in other Most At Risk Populations like in Malawi, they are targeted as part of sexual minority groups that include sex workers, prisoners and the LGBTI community. Center for Development of People (CEDEP) which has been in operation since 2005 has activities that include health education and social support for the Malawi gay community. Their mission includes and prisoners. CEDEP engages law and policy makers in legal reform, whilst building capacity to undertake effective advocacy.

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<sup>12</sup> UNGASS report ,2010

<sup>13</sup> UNGASS report, 2010.

## 4.5 Challenges faced by implementers of MSM programmes

Most HIV and AIDS programmes in the Southern Africa region face challenges that range from being poorly funded to lack of adequately qualified and experienced personnel, stigma, community “cultural” and “religious” resistance, bad policy and legal environment, and many other factors. It is imperative to note that MSM also encounter all the other general problems faced by their heterosexual counterparts in addition to the problems that may be exclusive to them as a group. Somestimes, organisations that implement LGBTI programmes face harassment by state agents with their premises often raided and ransacked.

Some of the challenges faced in implementing MSM programmes are highlighted in *The Journal of International AIDS Society* published in 2011. The journal reported that the Ministry of Health and Social Welfare in Lesotho and the Johns Hopkins School of Public Health conducted a study on MSM which was funded as a joint initiative between UNAIDS and UNDP in Lesotho. Activities of the study were facilitated by MATRIX. This study demonstrated high levels of fear by MSM in accessing healthcare, as well as blackmail, which was associated with disclosure of sexual orientation to a healthcare worker. Moreover, fear of seeking healthcare was significantly associated with lower rates of condom usage during anal sex among MSM. These structural barriers limit the ability to implement biomedical interventions, further highlighting the need for interventions for MSM to simultaneously address multiple levels of HIV risk, including at the level of the individual, community and government<sup>14</sup>.

## 4.6 The role of media

Journalists and other social communicators are inevitably part of the cultural and religious socialisation that often negatively stereotypes sexual minorities. The fact that journalists and situated interpreters of sexual difference requires rigorous and continuous attitude training with a view to reinforcing reflexive practice on reporting sexual minorities. The impact of attitude training on journalists role especially on MSM programming has been mixed. On the one hand, it has help ameliorate the negative attitudes towards MSM and brought about reporting that empathises and identifies with their predicaments in accessing health services. As such, new positive and progressive training is beginning to show due to attitude change by some journalists. On the other hand, the unintended impact of such training has been the crystallisation of negative perceptions by some journalists thus reinforcing the stigma and homophobia to MSM who share personal experiences as part of the training strategies.

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<sup>14</sup> The Journal of International AIDS Society- Lesotho Study , July 2011.

In countries where homosexuality is criminalised, mainly state controlled media has demonised MSM. They have facilitated the churning of hate speech by politicians and church leaders. Examples are articles that came out after Zambian president had indicated support of gay rights during his election campaign in 2012. The way the reactions from clergy were reported could have been more supportive of MSM. A sensitive reporter can still use an otherwise derogative and homophobic remark and turn it to be in support of MSM. The remarks could be used as a starting point to educate the public on MSM issues and could also be used as a platform to denounce the draconian laws that criminalise adult consensual sex in same sex relations. Media helped the public to follow and see how a President like Joyce Banda initially showed support for gay rights but reneged after public pressure, especially from traditional leaders. The debate and proceedings were responsibly covered.

Media has also been useful in exposing some of the human rights violations by having articles that narrate the harassment and torture inflicted upon some MSM as well as organisations that support MSM. For example, the Malawi gay couple was imprisoned after having a wedding ceremony. The story was shared in many spaces that include electronic forum discussions and social networks. Mainstream media and the Internet have been used for advocacy through for, example, social network petitions where fans sign in support of certain causes.

# SECTION 5:

## RECOMMENDATIONS

## 5.1 General Recommendations

This section mainly summarises the report's arguments and observations, and also makes recommendations for the way forward in terms of what needs to be done. The report has shown that in most countries that constituted the case studies of the study, there is consistent evidence that HIV disproportionately affects MSM. There are individual and structural risk factors driving HIV infections and prevalence among MSM in Southern Africa. The study has also shown that all interventions that seek to address the problems facing MSM as sexual minorities must mainstream human rights. The rights based approach can also maximize the effectiveness of biomedical prevention strategies. To improve health and human rights for MSM in Southern Africa, a comprehensive multi-stakeholder effort that addresses all aspects of the problem is needed.<sup>15</sup> For example, a minimum package of essential services to protect MSM from HIV risks has to be in place: counselling, distribution of condoms and other safe sex measures, community-based prevention efforts, HIV testing, and increased use of antiretroviral therapy treatment or ARV. Equally important are policy efforts to decriminalize MSM rights to sexual choice, institute anti-homophobia policies, and programmes to educate health care workers and reduce stigma in health care settings.

## 5.2 Recommendations on the role of media

The media has a special role to play in HIV prevention approaches like the biomedical, behavioural and socio-cultural interventions. For journalists to effectively play their role, they need to go through attitude training so that they can reflect on how their gender, sexuality, and social attitudes influence their perceptions of sexual difference. Reflective practice means that journalists can rethink their role as agenda setters on social and health problems facing sexual minorities. They need to take a professional commitment to bring the issue of MSM health risks to the forefront of public debate and policy in the region.

The news media also need to be educated about MSM issues. They need to know about sexual orientations and sexual choices people make and understand why men have sex with men. They also need to know enough to have an attitude change as well as to be able to proactively report issues that affect MSM. This may stimulate public debate and dialogue on MSM and HIV. Electronic, print and online media can provide the platform for such debate while NGOs can incentivise the sexual minority programming and articles. Given the level of hostility and homophobia, it is important to make efforts to confront key drivers of homophobia

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<sup>15</sup> Stefan Baral, MD MPH MBA The burden of HIV, the status of prevention, and human rights contexts among MSM in Africa- 2012.

at national level, hence the need to scale up activities that promote dialogue. There is a need to continue engaging, advocating and lobbying policy makers and traditional leaders on sexual rights at national level.

There is also need to bring MSM discussion not only in HIV and AIDS related events like World AIDS Day (WAD) themes but also in Human rights related events such as the 16 days of Activism against Gender Based Violence (GBV). Such initiatives would help to scale up information dissemination on LGBTI issues so as to increase knowledge that would inoculate people against myths and misconceptions on sexual minorities.

The media can also target MSM with messages that inform and encourage them to identify their sexual health problems such as STIs and seek treatment timely. They can also be used to fight stigmatisation of MSM that open up about STIs.

In the final analysis, the media has a role in promoting and in advocating for policy change as well as in increasing and improving availability of HIV and AIDS services to MSM through the following:

- Sensitise society and key stakeholders to the concept of universal and non-discrimination of the rights of MSM. The respect for LGBTI rights is basically the respect of human rights and fundamental freedoms enshrined in international law. LGBTI people are not asking for extra rights, they just want to enjoy those rights that everyone else is entitled to.
- Advocate for funding partners to fund HIV and AIDS programs for MSM and allocate adequate human and financial resources to assist countries in their efforts to ensure universal access to HIV treatment, care, and support programs for MSM.

### 5.3 Recommendations on the role of human rights activists

Human rights activists also play an important role in defending the rights of sexual minorities in general, and MSM in particular. Organisations involved in this area of advocacy may play varying and diverse roles that include the following:

- Provide information and training about the nature and legitimacy of LGBTI rights. Government officials and other actors are more inclined to cooperate if they have been conscientised about these issues and understand the work and the reason for undertaking prioritising it in the policy agenda.

- There should be a continuous effort to inform and train service providers by giving them information on basics of sexuality from social and biological perspectives. Facilitate efforts to conduct baseline and on-going surveys to gather data and to monitor and evaluate the state of the HIV epidemic among MSM.
- Advocate for countries to develop evidence-based plans and programs to scale up access to specific, culturally appropriate HIV prevention, treatment, care, and support services for MSM and develop indicators for reporting progress in HIV treatment, care, and support programs for MSM.
- Identify best practice models and approaches that can improve universal access to HIV and AIDS prevention, care, treatment, and support programs for MSM.
- Consider mainstreaming MSM programmes to other sexual and reproductive health programming since policies designed to promote universal access to HIV services often do not adequately protect MSM and other sexual minorities.
- Promoting community participation in providing essential services for MSM is also critical to producing policies that promote the health rights of MSM thus improving their access to HIV testing, treatment, and care.

Clearly, there are overlaps between the roles of the media and those of the human rights defenders. This is because the media practitioners should be human rights defenders and their role must always be underpinned by the rights discourse. As such, collaboration between Human rights activists and the news media is important and can yield positive results not only in setting the public policy agenda on the sexual and reproductive rights of sexual minorities, but also in mitigating the spread of HIV/AIDS.

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