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The overlooked epidemic: Addressing HIV prevention and treatment among men who have sex with men in sub-Saharan Africa

National AIDS Control Council of Kenya

Population Council

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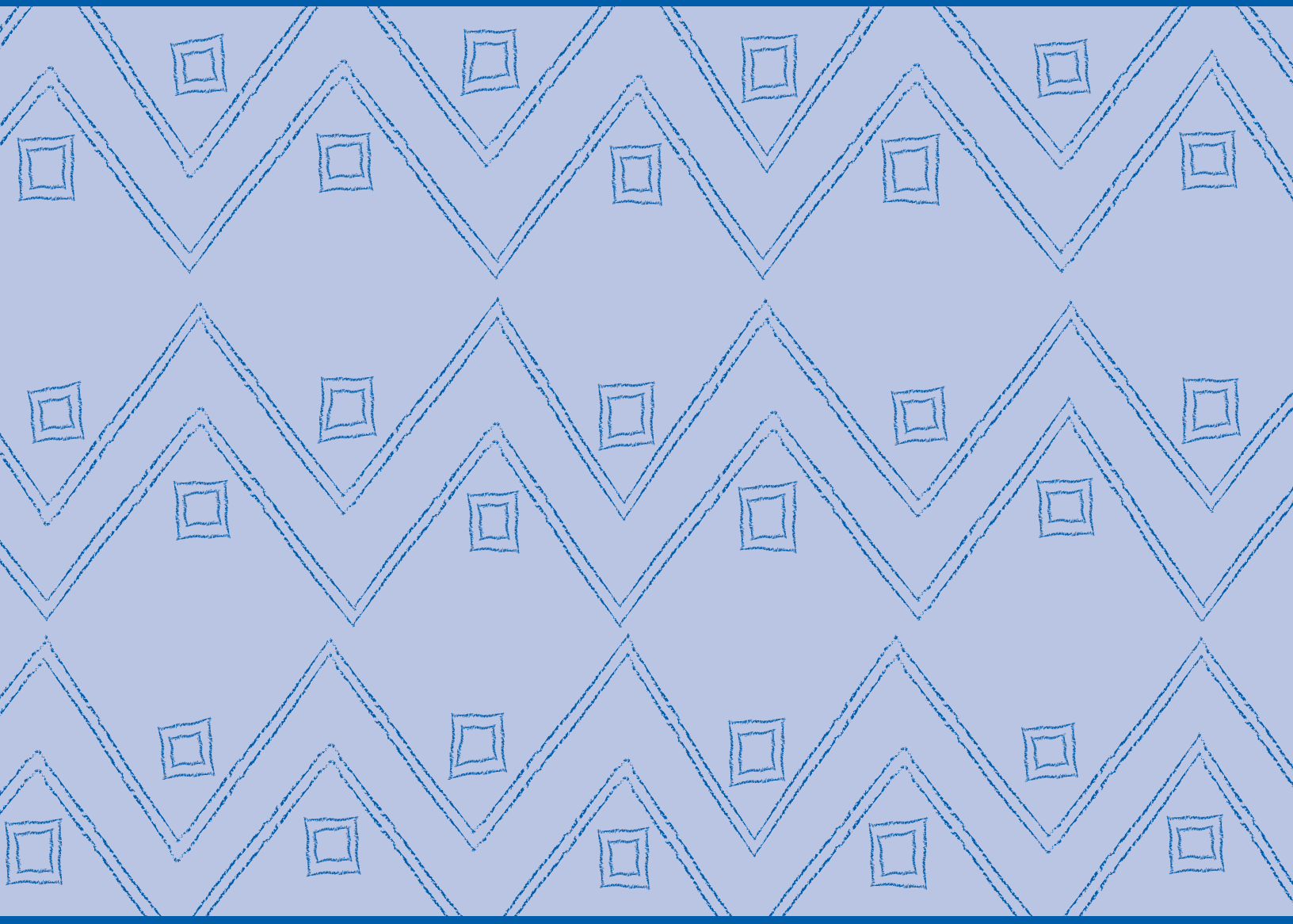

Report of a Consultation
Nairobi, Kenya
14–15 May 2008

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National AIDS Control Council

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The Population Council conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health.

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ACRONYMS

ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
CEDEP	Center for the Development of People (Malawi)
DHS	Demographic and Health Surveys
GALCK	Gay and Lesbian Coalition of Kenya
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IRB	Institutional Review Board
ICRH	International Centre for Reproductive Health (Kenya)
IGLHRC	International Gay and Lesbian Human Rights Commission
KEMRI	Kenya Medical Research Institute
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
Liverpool VCT	Liverpool Voluntary Counseling & Testing, Care & Treatment
MARP	Most-at-risk Population
MOH	Ministry of Health
MSM	Men who have Sex with Men
MSW	Male Sex Worker (Who has Sex with Men)
KAVI	Kenya AIDS Vaccine Initiative
KNASP	Kenya National AIDS Strategic Plan
M&E	Monitoring and Evaluation
NACA	National Agency for the Control of AIDS (Nigeria)
NACC	National AIDS Control Council (Kenya)
NIH	National Institutes of Health
NGO	Non-governmental Organization
NSF	National Strategic Framework
NSP	National Strategic Plan
RDS	Respondent-driven Sampling
STI	Sexually Transmitted Infection
UCSF	University of California, San Francisco
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WSW	Women who have Sex with Women

INTRODUCTION

Globally, less than one out of 20 men who have sex with men (MSM) has access to HIV prevention and care.[1] This is evident in much of the developing world—and in Africa in particular—where the stigmatization, discrimination, and criminalization of homosexual behavior persists, and where the existence of MSM has been publicly denied at all levels including by some heads of state. As a result, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has declared that: "Faced with legal or social sanctions, men having sex with men are either excluded from, or exclude themselves from, sexual health and welfare agencies because they fear being identified as homosexual."[2] In addition, even when MSM are aware of general HIV prevention interventions, misconceptions about the risk of their own sexual practices may preclude them from accessing services. Moreover, HIV service providers are not always trained or equipped to meet the specific prevention and treatment needs of MSM.

The contribution of HIV infection among MSM to overall prevalence levels is not negligible. UNAIDS has estimated that at least 5 to 10 percent of all HIV infections globally occur through male-to-male sexual activity. In Africa, recent studies have reported that 25 percent of MSM in coastal Kenya[3] and 22 percent in Dakar, Senegal[4] are HIV-positive. Other studies in Africa documented high proportions of MSM reporting recent sexual relationships with women and bisexual men, indicating that the sexual networks of MSM extend to the general population.

In spite of the high risk of HIV infection and evidence of extensive sexual networks, national HIV programs in Africa have been slow to address MSM in prevention and treatment efforts. This neglect is largely a product of the aforementioned denial, stigma, discrimination, and criminalization, but also because strong evidence supporting the need and guidelines for action has previously been unavailable. Informed discussion among key HIV policymakers in African governments is critical to legitimize the need for MSM-specific HIV prevention and treatment programs, and to develop guidelines for implementation.

To address these issues, the Population Council and the National AIDS Control Council (NACC) of Kenya convened a meeting on 14–15 May 2008 entitled, *The Overlooked Epidemic: Addressing HIV Prevention and Treatment among Men Who Have Sex with Men in Sub-Saharan Africa*.[5] The Population Council has been at the forefront of efforts to document the existence of MSM and their vulnerability to HIV in the face of denial and rhetoric. NACC, which took the pioneering step of recognizing MSM in the 2005/6 to 2009/10 Kenya National AIDS Strategic Plan (KNASP), is committed to developing a strategy for engaging MSM in the national response to HIV and is working to increase the number of organizations delivering services to MSM. This is one of the first such efforts of an African government.

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[1] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2006 report on the global AIDS epidemic. Geneva: UNAIDS; 2006.

[2] Ibid.

[3] Sanders EJ, Graham SM, Okuku HS, van der Elst EM, Muhaari A, Davies A, et al. HIV-1 infection in high risk men who have sex with men in Mombasa, Kenya. *AIDS* 2007;21:2513-2520.

[4] Wade AS, Kane CT, Diallo PAN, Diop AK, Gueye K, Mboup S, et al. HIV infection and sexually transmitted infections among men who have sex with men in Senegal. *AIDS* 2005;19:2133-2140.

[5] The meeting agenda can be found in Appendix A.

The goals of the meeting were to justify and legitimize discussion of MSM at the national and regional levels and to build support for prevention, testing, and treatment services for MSM. It brought together more than 60 representatives from national HIV programs, research organizations, bilateral donor agencies, multilateral programs, and MSM advocacy groups from 16 African countries[6] with the following objectives:

- To highlight research on MSM and HIV in Africa by the Population Council and other organizations.
- To share examples and lessons learned from programs currently addressing the specific needs of MSM in Africa and to identify opportunities for scale-up or adaptation to different countries.
- To discuss efforts to include MSM in national HIV programs and policy and to propose strategies to overcome the challenges and barriers to implementing HIV prevention and treatment programs for MSM in Africa.
- To document conclusions and next steps.

Presentation Topics Included

Overview of MSM and HIV issues in Africa: implications for national HIV programs

Current and future research evidence and results

Health services for MSM

Engaging MSM in HIV programs

Targeting MSM in national HIV plans

This report summarizes the key findings and lessons learned that emerged over the course of the meeting and outlines future priorities identified by participants. It is hoped that the proceedings and recommendations will provide an action agenda and programmatic framework for policy makers, program managers, and other stakeholders to implement high quality and effective HIV and AIDS services for a long-overlooked population.

[6] A list of meeting participants can be found in Appendix B.

OPENING REMARKS

Professor Miriam Were, Chairperson of the Kenya NACC, provided the keynote address for the meeting, setting a tone of open, informed, and respectful discussion. She underscored that "we must speak the truth in love," using compassion to make the case that MSM exist in all countries and that they deserve the same access to HIV prevention, care, and treatment as other populations. She pointed to the progress already made in reducing stigma and discrimination towards HIV-positive individuals in the general population as an encouraging sign that similar progress is possible for MSM.

Professor Were encouraged participants to remain cognizant of four key challenges over the course of this "landmark" meeting and into the future. First, participants must pay attention to each other, listening carefully and with tolerance. Second, it is essential to combat the fear that fuels homophobia, by affirming that not only do MSM exist, but acceptance of homosexuality will not result in "all of our children becoming homosexual." Third, programs for MSM must not only address HIV needs, but also support an overall high quality of life for MSM. Finally, she stressed that those concerned about HIV among MSM must take care to provide due attention to MSM as a vulnerable group, while not presenting them as the sole driver of the HIV epidemic.

Professor Were concluded by reminding participants to not only remain tolerant and compassionate, but to temper their fervor when addressing this controversial topic in the public area, stating that: "We should not meet fire with fire, as we might add more petrol and the house burns down."

THE EVIDENCE IN AFRICA: CURRENT KNOWLEDGE AND OUTSTANDING GAPS

Limited research has documented HIV prevalence and risk behaviors among MSM populations in sub-Saharan Africa.[7] Yet an evidence base is a key tool for advocating for policies and programs for MSM. For example, the Population Council's studies on MSM in Senegal and Kenya contributed to the inclusion of MSM in the national HIV/AIDS strategic plans of these two countries. Similarly, Liverpool Voluntary Counseling and Testing (VCT) initiated a pioneering HIV prevention, care, and treatment program for MSM in response to data from its VCT sites that indicated that HIV prevalence was two times higher among MSM compared to other men.

The first day of the meeting was dedicated to reviewing existing research and studies in the pipeline; sharing challenges and lessons learned; and identifying future research priorities.

The Evidence to Date

Key research findings cited by presenters included the following:

Sex between men occurs among and between Africans. In particular, recent data counters the prevailing belief that homosexual behavior in sub-Saharan Africa occurs only among foreigners. Dr. Phoebe Kajubi of the University of California, San Francisco (UCSF) presented a study using respondent-driven sampling (RDS) of MSM in Kampala, Uganda, in which the majority (92 percent) of respondents were Ugandans. Scott Geibel of the Population Council and Dr. Eduard Sanders of the Kenya Medical Research Institute (KEMRI) shared findings from a capture-recapture study that estimated 739 MSM sex workers were present in Mombasa, Kenya, and a related behavioral survey that found that 80 percent of their male clients were Kenyan citizens. In other countries where quantitative data is not available, anthropological studies and anecdotal evidence suggest that sex between African men indeed occurs.

Respondent-driven Sampling

Respondent-driven sampling (RDS) relies on individuals recruiting a limited number of their peers, who in turn recruit a limited number of their peers, continuing along this recruitment "chain" until the sampling goal is reached. The recruitment records are recording using a specially-designed software package, and statistical weights are applied to yield unbiased estimates of the target population's characteristics.

MSM are not a homogeneous population. Andrew Seale of UNAIDS underscored that MSM encompass a range of sexual and gender identities—such as homosexual, gay, bisexual, transgendered, or heterosexual—among people in various socio-cultural contexts. MSM may be married, particularly where discriminatory laws or social stigma of homosexual behavior exist. Homosexual practices can also be motivated by money or material gain. Adolescent males may experiment with homosexual

[7] A list of relevant publications can be found in Appendix C.

sex—the majority of participants in the UCSF Kampala study reported having their first sexual experience with another man before the age of 18. Finally, sex between men occurs in contexts in which men spend long periods of time with other men, such as in prisons, schools, or among migrant workers. In any of these contexts, sex between men may be consensual or coerced.

HIV rates are high among MSM, but vary by study and geographic location. Prevalence statistics cited during the meeting include: 23 percent in Mombasa and 25 percent in Nairobi, Kenya (Dr. Eduard Sanders, KEMRI); 12 percent in Unguja, Zanzibar (Dr. Mohammed Dahoma, Zanzibar AIDS Control Programme); 3 percent in Cross River, 10 percent in Kano, and 25 percent in Lagos, Nigeria (Alex Ogundipe, Nigeria National Agency for the Control of AIDS (NACA)); 21 percent in Malawi (Daveson Nyadani, Center for the Development of People (CEDEP)); and 25 percent in Ghana (Dr. Placide Tapsoba, Population Council). All of these estimates were markedly higher than HIV prevalence among the general population in the same settings.

Many MSM report high risk behavior. Reported condom use was low in numerous studies: 46 percent of the KEMRI Mombasa sample did not use condoms with casual sex partners; 37 percent in the UCSF Kampala study reported unprotected anal intercourse in the past six months; 14 percent of MSM reported condom use at last receptive sex in the Population Council Dakar study; and only 36 percent of MSM sex workers in the Council's Mombasa sample used condoms consistently with male clients. Studies also documented multiple sex partners among MSM: Dr. Harriet Birungi of the Population Council shared findings from Nairobi in which 18 percent of respondents reported two or more sexual partners in the past week and 47 percent within the past month. Dr. Placide Tapsoba, also of the Council, presented survey findings from Mali and Ghana in which three-quarters of respondents reported multiple sexual partners.

Lack of knowledge about risk behaviors and methods of protection may place MSM at risk of HIV. The Council's Mombasa study found that 35 percent of MSM sex workers did not know that HIV could be transmitted during anal intercourse, while only 21 percent knew that a water-based lubricant should be used with latex condoms. Similarly, the Council's Nairobi study found that only 26 percent of respondents had correct knowledge of water-based lubricants. Instead, 84 percent reporting used petroleum jelly, which can cause condom breakage and damage to rectal tissue, increasing risk of HIV acquisition during anal sex.

Sex work, like homosexual behavior, is illegal in many countries, and appropriate HIV prevention and treatment services often do not exist for sex workers. MSM who engage in sex work face dual stigma and discrimination and are likely to be disproportionately affected by HIV. A number of presenters found high proportions of MSM engaging in sex work: in the KEMRI Mombasa study, 75 percent of MSM reported payment for sex, as did 27 percent in the UCSF Kampala study.

Type of sex act may also affect HIV risk among MSM. The KEMRI Mombasa study found that receptive anal intercourse resulted in nearly a four-fold increase in HIV infection compared with insertive anal intercourse, and MSM who engaged in both insertive and receptive anal intercourse had an eight-fold higher risk compared with the reference group.

Finally, non-consensual sex, which carries increased HIV risk, is common among MSM. The Council's Senegal study found that 43 percent of respondents had been raped at least once, and 13 percent

had been raped by a policeman. Dr. Vasu Reddy of the Human Sciences Research Council described a recent survey of MSM in the Gauteng Township of South Africa, conducted by UCSF and the Perinatal HIV Research Unit, in which 45 percent of respondents had been coerced by other men to have unprotected anal intercourse.

Not all MSM engage in high risk behaviors, and they should not uniformly be labeled as a "high risk" group. The Population Council's study of MSM in Nairobi found that 75 percent of MSM reported condom use during their last anal sex act, and 21 percent reported having only one male sexual partner during the past year. In addition, 57 percent reported taking an HIV test—of which 98 percent received their test results—more than double the rate of the general population as reported by Demographic and Health Surveys (DHS) in 2003.

The sexual networks of MSM and concomitant risk of HIV extend to the general population. Forty percent of MSM in the UCSF Uganda sample and 60 percent in the KEMRI Mombasa sample reported having sex with women. In the Population Council's Nairobi study, 22 percent of MSM reported having at least one child. Among MSM sex workers, the Council's Mombasa study found that 15 percent had a female paying client, and 25 percent had a female non-paying partner in the past 30 days.

MSM face barriers to accessing appropriate HIV-related information and services. Confidentiality was cited as the most important concern of MSM seeking health care in the Council's Nairobi study. In addition, HIV service providers are often not trained or equipped to meet the specific HIV prevention and treatment needs of MSM. At the same time, health workers perceive that their MSM patients are not forthcoming regarding health problems because of the stigma attached to homosexual behavior. According to a STI clinical officer participating in the Council's Nairobi study,

> *It is difficult to provide services to MSM clients when they don't disclose the problem. I met one suffering from anal sores, but he said he was having anal allergy. It was difficult to know what to treat.*

In other instances, providers discriminate against, stigmatize, or even refuse to serve MSM, increasing their reluctance to seek health care. Finally, existing HIV-related information generally does not address risks related to homosexual transmission. A CEDEP study in Malawi found that 57 percent of MSM received HIV prevention information for MSM, while 93 percent received information on heterosexual prevention.

Innovative programs can increase access to services and reduce risk behaviors. In Dakar, the Population Council evaluated an intervention coordinated by the AIDS/STI Division within the Ministry of Health (MOH) with several partner institutions, including Africa Consultants International, the National AIDS Alliance, the Institute of Social Hygiene, ENDA Santé, and Family Health International. The intervention included training 40 MSM leaders and peer educators in behavior change communication (BCC) messages and equipping them with lubricant, condoms, and educational materials; working with 12 providers to deliver "MSM-friendly" services; and conducting advocacy such as education and sensitization of media, police, and community-based organizations (CBOs). It resulted in 1,200 clinical consultations, with 263 MSM referred for HIV counseling and testing. The International Centre for Reproductive Health (ICRH) launched a prevention intervention for MSW in Mombasa, which includes a drop-in center, training of peer educators in prevention and basic counseling, distribution of condoms and water-based lubricants, and sensitization and training of providers. The Population Council's evaluation of the intervention showed significant improvements

in correct knowledge of anal HIV transmission, correct knowledge of water-based lubrication, and condom use.

Challenges to Conducting Research with MSM

Conducting research related to any sexual behavior poses a number of challenges, given the sensitive nature of the topic and difficulty in obtaining reliable data. Desirability bias may also affect the quality of data if respondents, for example, over-report condom use. Research involving MSM is doubly challenging as homosexual behavior is stigmatized, denied, and often illegal in sub-Saharan Africa. As a result, justifying the need for research can be difficult, as can recruiting study participants and obtaining accurate self-reports of behaviors. Specific issues cited by presenters included the following:

Institutional Review Board (IRB) approval: A number of investigators experienced delays or failure in obtaining IRB approval for their research. Many IRB questions had more to do with curiosities about MSM than with actual ethical issues, posing unnecessary delays to starting the research. Dr. Phoebe Kajubi reported delays in IRB approval for the UCSF study in Kampala, not because of ethical concerns, but because the investigators needed to justify the rationale for research on a population that "does not exist." A CDC RDS study in Lusaka, Zambia, which was approved by CDC Atlanta in August 2007, has been impeded by the local ethical review board, which has posed a number of moral and legal questions about the research. For example, the local IRB requested assurance that participants would not be arrested by the police. Even after obtaining support from the Attorney General and MOH, the researchers have not been successful in allaying these concerns. Significant delays in ethical review application were also reported by CEDEP in Malawi and by the Population Council for its Nairobi study.

Incentives for participation in research: Determining appropriate incentives—which must encourage but not compel participation—can be a challenge in any study. It is of particular relevance, however, in studies involving MSM, which often rely on methods that involve participants receiving coupons and incentives

"The First Time Is the Hardest": Obtaining Local Ethical Approvals for MSM Studies

A roundtable workshop, moderated by Dr. Elizabeth Onjoro Measick of CDC Zambia, made the following suggestions for facilitating local ethical approval for research involving MSM in Africa:

1. Select terminology carefully when writing protocols. Use "Most-at-risk populations (MARPS)" in lieu of "MSM".
2. Design studies to include other populations, such as injecting drug users (IDUs) or the disabled.
3. Engage the National Institutes of Health (NIH) to work with local review boards during the early stages of proposal development.
4. Combine research with interventions. The outcomes of the research can inform the expansion of the program.
5. Engage the MSM community, including those who are HIV-positive, when developing studies. Put a face to the research.
6. Sensitize the media to the stigma and discrimination MSM face, as well as the need for research and programs to address their HIV risk.

to recruit their peers. As Dr. Wolfgang Hladik of CDC Uganda underscored, incentives that are trivial can result in low study participation. Conversely, those that are too substantial can compromise the ethical and scientific integrity of a study by, for example, leading to the selling, trading, duplication, or forging of recruitment coupons; attempts by individuals to participate more than once; or the coercion of peers to participate. In his presentation on a Zanzibar RDS study, Dr. Mohammed Dahoma explained that the original incentive, equivalent to funds for bus fare, had to be halved after the study was infiltrated by substance users, some of whom were not MSM but were purchasing recruitment coupons to receive the monetary incentive. Some substance users also harassed the MSM, deterring participation. Recruitment was slowed, as more stringent screening procedures were implemented.

Confidentiality: Ensuring confidentiality, while essential in any study, is of utmost importance in studies involving MSM given that homosexual behavior is often illegal in sub-Saharan African countries. Some MSM at risk of HIV engage in other stigmatized or illegal behaviors, such as injecting drug use or sex work, making it all the more critical to guarantee confidentiality—both to increase participation and to protect participants. Further, MSM who do not engage in these other behaviors may be discouraged from participating, as they do not want to be presumed to be IDUs or MSWs.

Controlling dissemination of data: Results of MSM studies may be too controversial to be released, thus undermining any potential impact they might have on policies or programs. Alternatively, if released, findings may be exaggerated or misrepresented by the media. Even if reported accurately, any attention to this controversial topic can produce negative repercussions. Dr. Paul Semugoma described how the Uganda government imposed fines on local radio stations that covered the issue of HIV risk among MSM. As a result, MSM researchers must take the additional step of engaging the media to ensure that study results are conveyed accurately and sensitively.

Managing the Media

A roundtable workshop, moderated by Dr. Placide Tapsoba of the Population Council, identified the following approaches for working with the media to ensure accurate and sensitive coverage of study results:

1. Develop a media engagement strategy from the outset of the project, and include the media as a stakeholder during this process.
2. Train researchers, program officers, and study participants in dealing with the media. If possible, identify a staff person dedicated to public relations.
3. Educate and sensitize the media—both writers and editors—on issues related to MSM and HIV. Provide training on basic scientific terminology (e.g., informed consent, representative sampling).
4. Package information in a media-friendly way: offer a precise summary rather than a long publication, and create a story for the media to tell, rather than only providing the facts.
5. Think proactively and learn lessons from previous projects to anticipate and preempt problematic situations.

Future Research Priorities

The studies shared during the meeting provided an important but limited window into HIV risk among MSM, with many unanswered questions remaining. A special roundtable workshop, moderated by Dr. Eduard Sanders of KEMRI and Dr. Wolfgang Hladik of CDC Uganda, was convened to formulate a research agenda and produced the following recommendations:

Principles of Research Involving MSM

- Participative formative research on MSM and their health priorities should provide a foundation for future research.
- MSM must be included in setting priorities for research and its implementation.
- Research on MSM should be linked to local action and dissemination.

Surveillance Priorities

- Routine measurement and mapping of MSM populations from national level surveys including AIDS indicator surveys and DHS surveys.
- Health needs assessment for MSM populations.
- Epidemic modeling (using evidence-based research) to estimate the incidence of and projected HIV prevalence among MSM populations and its contribution to the overall epidemic.

Research Priorities

- Descriptions of social and sexual networks and norms of MSM populations—including homosexual activity in prisons.
- Relationships between sexual identities and increased or decreased risk behaviors.
- Barriers to utilization of and compliance with health services, including stigma.
- Patterns of mobility among MSM populations.
- Political, moral, legal, religious, and cultural barriers to recognizing MSM needs in Africa.
- Relationship between alcohol, drugs, violence, and HIV risk.
- Financial and other drivers of transactional sex.
- Barriers to condom use.
- Resource and training needs, including initial medical training and sensitization of existing medical and HIV control staff.

Operations Research Priorities

- Development of evidence-based models of behavioral interventions (i.e., psychosocial, sexual, and behavioral) that address the needs of diverse MSM populations.
- Review, adaptation, and evaluation of best practice HIV preventive models (both regionally and internationally).
- Testing effectiveness of pre- and post-exposure prophylaxis, access to care, and health information message and systems interventions in different resource contexts.

- Cost-effectiveness analysis of behavioral and public health interventions.
- Testing different models of risk reduction counseling and their effectiveness for different MSM populations.
- Systematic review of women having sex with women (WSW) and associated HIV risk factors.

In addition to the aforementioned priorities, the following research questions received attention at numerous points during the meeting:

Additional information on the population size, location, risk behaviors, and incidence of HIV infection among MSM: Research in the pipeline will provide further insight into these questions. For example, CDC Zambia is awaiting IRB approval for a study of MSM in Lusaka using RDS to estimate HIV infection and related sexual risk behaviors, including the extent of MSM sexual interaction with the female population. In Uganda, Makerere University, the MOH, and CDC Uganda are planning a survey of MSM and other MARPs using RDS in Kampala to describe risk behaviors and estimate HIV/STI prevalence using biological measures such as blood draws, rectal and vaginal swabs, and urine. Still, national data—which is most critical to planning national responses—is lacking.

Deeper research on the context in which risk behaviors occur: Existing data underscores that HIV risk behaviors do not exist in a vacuum, but rather, correlate with broader social, economic, psychological, and behavioral factors. For instance, the UCSF/Perinatal HIV Research Unit survey in Gauteng determined that unprotected anal intercourse was associated with moderate to high levels of alcohol use. Similarly, the Population Council's Mombasa MSW study found that using alcohol more than three days per week was associated with unprotected anal sex with male clients. Sexual identity may also influence risk behaviors—Dr. Vasu Reddy cited a South African study by Dr. Theo Sandfort of Columbia University, which found that MSM who had not been tested for HIV were also less likely to be open about their homosexuality or to be involved in the gay culture. A related implication of this finding is that those who do not have a strong homosexual or gay identity may be harder to reach in both research and programs. Thus, further research is needed on the roles that these and other factors, such as stigma and self-stigma, poverty, unemployment, discrimination, and violence play in MSM's HIV risk and access to services.

The extent to which unprotected anal intercourse occurs among heterosexual couples, and its role in HIV transmission: Anal intercourse remains a taboo subject for heterosexual as well as homosexual couples. As a result, a paucity of data exists—among that available are a 2006 study by Dr. Tim Lane of UCSF, in which 3.6 percent of heterosexuals aged 15 to 24 reported anal intercourse, and research in Zambia, described by Dr. Elizabeth Measick, which found that men engage in anal sex with women as a pregnancy prevention technique.

DEVELOPING PROGRAMS AND ENGAGING MSM

The second day of the meeting focused on programmatic experiences for MSM in Africa. While programs targeting MSM are limited, existing pilot activities demonstrate that delivering services to MSM is both necessary and feasible. At the same time, presenters highlighted a number of challenges that future programmatic efforts must seek to overcome.

Elements of Successful Programs

In Kenya and South Africa, enabling policy environments have afforded unique opportunities for the delivery of services to MSM. The experiences of Liverpool VCT, the Kenya AIDS Vaccine Initiative (KAVI), ICRH, and KEMRI in Kenya, and of OUT in South Africa illustrate the requisite elements to developing and implementing successful programs:

Close working relationships with the MOH and national AIDS program: Many presenters cited close working relationships with key government bodies as critical for gaining support for and legitimizing to their programs. Dr. Nduku Kilonzo of Liverpool VCT described how a partnership with the Kenya NACC and other government stakeholders, which included the provision of technical assistance, ensured prioritization of MSM as a target population and allowed for the mainstreaming of MSM into other HIV activities, such as BCC strategy development. Peter Njane of the Gay and Lesbian Coalition of Kenya (GALCK) underscored the reciprocal relationship that a number of advocacy groups have forged with the Kenya NACC. These groups have worked closely with the NACC to facilitate inclusion of MSM in the KNASP and during events such as World AIDS Day, and they feel valued by the NACC as stakeholders. Finally, Dawie Nel of OUT credited much of its success to long-term relationships with the government, which have resulted in funding from the Gauteng Department of Health and opportunities for policy review.

Working with mainstream organizations: When mainstream organizations implement MSM programs, or work in conjunction with MSM groups, they can help to garner widespread acceptance of both MSM and the programs seeking to reach them. Dr. Nduku Kilonzo noted that Liverpool VCT, as an established HIV organization, was able to incorporate MSM services perhaps more seamlessly than a new or exclusively lesbian, gay, bisexual, transgender, intersex (LGBTI) organization. Likewise, OUT has partnered with select progressive organizations, such as the South African Council of Churches and the Human Rights Commission, to address the issue of homophobia. It is also working to mainstream services by training teachers through the South Africa Department of Education and by engaging service providers in sensitivity training and product development. Such alliances can also provide essential support to LGBTI organizations in times of challenge— Ian Swartz of the Rainbow Project in Namibia described how efforts to engage and build the capacity of mainstream organizations later paid off when these organizations provided essential support that prevented the Rainbow Project from being shut down by opponents.

Involvement of MSM in the development and implementation of programs of which they are the intended beneficiaries: As noted above, MSM encompass a vast array of identities and behaviors. In effect, programs to address their needs are not "one size fits all." A number of presenters, including

Dr. Gaudensia Mutua of KAVI and Ian Swartz of the Rainbow Project, emphasized that the best way to develop effective programming is to engage the target population from the outset, both in terms of planning and implementation.

Using MSM as peer educators and counselors can also strengthen program quality. Nzioki Kingola described ICRH's training of 40 MSM as peer educators in an effort to increase knowledge and skills related to HIV and STI prevention, effect behavior change, improve self esteem and empowerment, reduce stigma, and provide facilitation and leadership skills. More than 1,900 MSM have been reached through peer education, and the United States Agency for International Development (USAID) provided funding to train an additional 100 peer educators. Liverpool VCT also implemented a peer-led program in which MSM clients reach out to other MSM to access VCT; the organization has found that peer-led services elicit the greatest response among the various interventions it has implemented. Finally, Allan Muhaari explained how KEMRI successfully utilized MSM sex workers as outreach workers, who are trained to go out in field teams to offer counseling to MSW, and then to meet weekly to discuss their experiences in the field.

Inclusion of broader support services: Whenever possible, service delivery should be extended beyond HIV prevention, care, and treatment to meet the broader health and psychosocial needs of MSM. A number of programs have, for example, worked to incorporate substance abuse counseling and psychosocial support services. ICRH's peer educators have received intensive harm reduction training by Support for Addiction Prevention and Treatment in Africa, with follow up sessions to assess progress. OUT has also prioritized substance use and risk taking in its service delivery; in collaboration with the South Africa Medical Research Council, it has provided 360 people per year with a risk reduction interview. To address the psychosocial issues faced by many MSM, ICRH has trained its peer educators in basic counseling, backed by ICRH counselors who provide additional psychosocial support. KEMRI's field team of counselors has provided a forum for MSW to share and discuss experiences such as harassment by authorities; bashing, hostility, sexual harassment, and violence; disownment by families; and homelessness. KEMRI has also facilitated a "Stay Alive" support group for HIV-positive MSM, with members referred from counselors. Liverpool VCT and OUT have also created support groups for MSM.

Training and sensitizing providers on "MSM-friendly" services: Research to date has demonstrated that many providers are ill-equipped to deliver appropriate services for MSM. In response, current programs such as Liverpool VCT and KAVI are providing sensitivity training to their counselors and medical staff. ICRH has taken the additional step of asking MSM to identify providers from Mombasa-area health facilities, who then receive training on anal and oral STIs; provision of non-judgmental, supportive, and sensitive services; and stigma reduction. ICRH also held a "confidence-building" meeting during which MSM shared their experiences with these service providers.

Distribution of condoms and water-based lubricants: HIV programs have long recognized the importance of guaranteeing access to HIV-prevention methods. Since MSM may not access traditional supply outlets, they may require targeted distribution. ICRH has distributed more than two million condoms and 12,000 sachets of water-based lubricants to MSM and others through its drop-in center, 77 "hotspots," and by peer educators who offer distribution to peers, guest houses, and private homes. Liverpool VCT has successfully distributed 50,000 condoms and 30,000 lubricants to MSM nationally in Kenya. Distribution of water-based lubricants is particularly imperative, given the strong evidence

that many MSM rely on petroleum jelly or other non-water-based lubricants. Unfortunately, water-based lubricants are expensive, and some donors will not pay for them.

Creation of "safe spaces": In light of research demonstrating that MSM may be reluctant to access services through mainstream providers, some programs are offering dedicated and specialized services for MSM. ICRH created a drop-in center in Mombasa to provide MSM-friendly health information, condoms, lubricants, HIV counseling and testing, referral to other clinic-based services, and to serve as a venue for peer-educator sessions and meetings. ICRH has concluded that this "safe space" enhances uptake of services and has opened a second drop-in center in Malindi. OUT's on-site clinic has established separate "male" and "female" days for STI and HIV testing and treatment, as well as general medical exams, in an effort to increase the comfort of both MSM and WSW in accessing services. There remain concerns, however, that some drop-in centers may be misperceived as MSM mobilizing or "recruitment" centers. The drop-in center in Malindi recently became a focus of community tension, and it became necessary to suspend services.

Challenges to Delivering Services and Engaging MSM

Despite these success stories, HIV and other services for MSM remain scarce or non-existent in most African countries. During the course of the meeting, the following challenges emerged as major barriers to delivering such services:

Religious and cultural hostility towards MSM: In many countries, MSM are considered both un-Christian and un-African. Alex Ogundipe of the Nigeria NACA described, for instance, how religious leaders threatened to walk out of a National Strategic Framework consultative process when they learned that MSM would be included in the discussion. Programmers must therefore identify and engage supportive religious, political, and community leaders as a first step to promoting greater acceptance of MSM and facilitating access to care. In South Africa, OUT is working to strengthen community norms of sexual safety both at the macro level through messaging in the media and the establishment of a community center, and at the micro level through peer education in specific social and sexual networks.

Negative attitudes and lack of knowledge among providers: Dr. Paul Semugoma of Uganda shared his first experience treating a married father who also reported having sex with men, and how unprepared he was to counsel this patient on HIV prevention. Seeking to educate himself, he found a dearth of resources for providers interested in serving MSM. In addition, Nzioki Kingola described providers who treat MSM as abnormal, or who ridicule and refuse to serve them. Many MSM fear that they will experience discrimination or inappropriate care from providers, choosing instead to self-medicate or to seek treatment from their peers.

Inadequate information, education, and communication (IEC) and BCC materials for MSM: A lack of HIV prevention information related to anal intercourse perpetuates the misbelief that only vaginal intercourse transmits HIV, while anal sex is "safe." Both Liverpool VCT and KAVI have created IEC leaflets and posters that explain the risks associated with anal sex and related STI symptoms, but additional materials tailored to specific MSM populations are needed.

Cost and limited geographic scope of services: Funding services for MSM can be particularly challenging given the controversy that surrounds them and the limited donor pool for all HIV service delivery programs. As noted previously, water-based lubricants are particularly expensive and in short supply. Moreover, existing programs are reaching only a narrow portion of MSM in need—the Council's Senegal intervention was concentrated in Dakar. Until recently, services in Kenya were available in only parts of Nairobi and Mombasa. Even in South Africa, where the most services are available, rural MSM have yet to be reached.

Meeting the myriad of needs of MSM, especially for those who are HIV-positive: As illustrated by a number of presenters, many MSM face a host of health and psychosocial problems—including substance abuse, coercive sex, marginalization from family, stigma, discrimination, violence, poverty, and homelessness—which existing services are unable to address. For example, while working with MSM sex workers, ICRH experienced demands for money and personalized attention beyond the program's capacity. HIV-positive MSM are further challenged by their "double" stigma. Dr. Gaudensia Mutua described KAVI's success providing on-site antiretroviral therapy (ART) and referrals to other sources of care, but cited a lack support groups and role models for MSM living with HIV/AIDS.

Future Programmatic Priorities

The activities shared by presenters from Kenya and South Africa are promising and offer a number of lessons for future MSM programs. At the same time, they illustrate the extremely limited availability of services for MSM in Africa, and the urgent need to determine best practices in service delivery and concomitant scale-up. A roundtable workshop, moderated by Lorna Dias of Liverpool VCT and Dr. Gaudensia Mutua of KAVI, identified the following recommendations to increase and improve HIV services for MSM in Africa:

Outreach, Advocacy, and Capacity Building

- Include government officials, provincial and district personnel, and medical personnel in project advisory committees.
- Sensitize religious leaders, politicians, and key policy makers in a non-confrontational way. Identify individual champions and use a peer approach (i.e., religious leader to religious leader) for the greatest impact.
- Engage the media to report on MSM issues. Provide training for individual reporters and editors, using literature reviews and evidence-based research.
- Target and work with the police to reduce stigma and violence and improve community norms towards MSM.
- Strengthen partnerships between groups working with MSM and other progressive organizations.
- Encourage local entities to produce, and donors to pay for, water-based lubricants, condoms, and MSM-inclusive IEC/BCC materials.
- Include MSM in the development and implementation of programs.
- Avoid the use of terminology that is stigmatizing; for example, include MSM among other vulnerable populations such as youth, women, and sex workers, rather than separating them as a single high risk group.

- Integrate other marginalized groups, such as the disabled, with MSM groups to mutually advance advocacy work.
- Share information about and experiences while working with MSM through manuals, documented research, journals, or other reference materials.
- Build the capacity of existing support and advocacy groups.

Prevention, Care, and Treatment

- Use peer educators to reach target groups with prevention messages in bars or other public places.
- Identify service providers and facilities willing to serve MSM—including VCT centers, private hospitals and clinics, and public clinics. Provide appropriate clinical services, counseling, and sensitivity training; monitor and evaluate progress; and scale-up to other areas if feasible.
- Provide training on MSM health issues to training institutions such as nursing colleges, medical schools, counseling schools, and universities.
- Create linkages and referrals between MSM community groups and MSM-friendly health care facilities.
- Increase the availability of comprehensive counseling to address psychological issues, including internalized homophobia, and to promote self-acceptance.

CROSS-CUTTING THEMES

Over the course of the meeting, a number of themes emerged that transcend specific research and programmatic experiences. While all of these issues are broad, the approach to each has implications for any effort to address the HIV and other needs of MSM. These cross-cutting themes include:

Terminology: There is a lack of a common or precise terminology for the MSM population. As highlighted by various presenters, the term "MSM" may be used to describe a diverse group that includes gay, bisexual, and married men; sex workers; and situational homosexuals such as prisoners, miners, hostel dwellers, or migrant workers. To use one term to capture all of these groups is to conflate the complex and often fluid identities and behaviors that involve same-sex sexual intercourse.

While the term MSM may be appropriate at a broad research or policy level, it is less likely to be universally accepted or understood at the advocacy, community, or individual levels, where terminology is used to differentiate identities (i.e., gay or bisexual) from behaviors (i.e., MSM). Researchers and programmers must therefore select terminology that is most likely to resonate with their target populations. Dawie Nel explained that OUT, for instance, is more concerned with identity over behavior and therefore targets its services towards gays and lesbians, not MSM. Similarly, IEC/BCC materials created for MSM may not be utilized by men with a strong gay identity.

Finally, when describing HIV risk among MSM, it is important to avoid terminology that propagates stigma for this already marginalized population. As Cary Alan Johnson of the International Gay and Lesbian Human Rights Commission (IGLHRC) underscored, terms such as "high risk group" or "driver of the epidemic" suggest that the MSM population is *a* problem, rather than a population *with* problems. In addition, terms such as "hard to reach" or "hard to engage" further isolate and stigmatize the MSM population. Because not all MSM are at high risk of HIV, language that focuses on specific risk behaviors is preferable to condemnatory language to describe the entire population.

Use of a public health versus a human rights approach: Participants debated the relative merits of using a public health or a human rights argument when advocating for increased attention to HIV among MSM. The Kenya NACC has taken a public health perspective that focuses on prevention, using the rationale that a comprehensive policy cannot seek to prevent new infections unless it targets all groups. The public health approach also formed the basis for the programs that have been implemented to date. Dr. Placide Tapsoba explained that such a justification was integral to the Population Council's success in Senegal—to have used an activist, confrontational, or even a right-to-health care argument would have been futile. Dr. Nduku Kilonzo of Liverpool VCT seconded this sentiment, noting that the public health approach is particularly strategic in the context where homosexuality is illegal, as it allows for the utilization of existing avenues to deliver services.

On the other hand, the absence of services, as well as the stigma, discrimination, violence, and other human rights violations experienced by MSM can increase their risk of HIV. As Cary Alan Johnson emphasized, few African governments include MSM in their national AIDS strategies, and exclude MSM from participating in civil society committees that inform these policies—the result is the denial of health care. Moreover, sodomy laws deter MSM from accessing HIV services, increasing their vulnerability to infection and suggesting that their lives are expendable.

While some participants favored one approach over the other, there was also a general recognition that both are not only valid, but also necessary to overcome the many challenges surrounding the issue of HIV and MSM. As one participant aptly noted, "When you walk over hot coals, you need both of your shoes."

Legal status of MSM: The criminalization of male-to-male sexual activity poses a barrier to conducting research and discourages MSM from seeking services. For example, some providers worry that they will be arrested for delivering services to MSM, while some MSM fear arrest for seeking services. Among many anecdotes shared at the meeting were the recent arrests and imprisonment of HIV-positive MSM in Egypt. Even Kenya, where great programmatic progress has been made, the penal code continues to criminalize sex between men.

Perhaps more important than actual laws is the perception of legal status of MSM. Dawie Nel explained that in South Africa, where the constitution protects same-sex sexual behavior and affords legal protections such as the right to marry, MSM are still refused services or do not seek health care out of fear of prosecution or discrimination.

Human rights protections afforded under national strategic plans (NSPs) and other policies may offer an opportunity to circumvent criminalization laws. For example, the Zambia NSP describes a human rights approach that should be "people centered," and Zambia law dictates that all have the right not to be discriminated against on any grounds. Basing programs for MSM on such policies offers a more immediate solution to national legal reform, which may be very difficult to achieve.

The advantages of an enabling environment: It was widely recognized during the meeting that the progress made in Kenya is largely a product of the NACC's support for HIV research and programming for MSM. Many—if not all—of the researchers and programmers working in Kenya acknowledged

"Explain Yourselves": How Can National AIDS Programs Assist the Research Process?

A roundtable workshop, moderated by Dr. Mohammed Dahoma of the Zanzibar AIDS Control Programme, made the following recommendations for researchers seeking support from national AIDS programs:

1. Recognize that some national AIDS programs will be in favor of a focus on MSM; others will not.
2. Use epidemic modeling as a tool of persuasion.
3. Advocate at the donor level for inclusion of MSM in National Strategic Plans (NSPs), as most NSPs are externally funded.
4. Make the case to national AIDS programs that they are required to report on certain MSM indicators (e.g., UNGASS) and that they have signed onto international treaties.
5. Efforts are needed not only to include MSM in NSPs, but also to follow-up when the NSP is put into action.
6. MSM should be involved in the design, implementation, and monitoring and evaluation (M&E) of NSPs.
7. Advocate for national AIDS programs to address decriminalization of MSM.
8. Share information between stakeholders, including researchers, advocates, and national AIDS programs, and agree on areas of collaboration.

the role that the NACC has played in facilitating their successes. In comparison, participants from other countries, such as Malawi, Namibia, and Zambia, voiced their frustrations in trying to work within an unsupportive government climate.

Nigeria offers another example in which the NACA has sought to address MSM in its National Strategic Framework (NSF) through the target population of high risk groups. However, as described by Alex Ogundipe, it has faced a number of challenges including a hostile policy and legislative environment, with recent attempts by the National Assembly to pass a sodomy law; threats from religious leaders to cease participation in the NSF consultative process; the limited capacity of both NACA and MSM advocacy groups to engage wider society; and funding limitations—80 percent of NACA's funding is driven by donors, who are not necessarily allocating resources towards MSM.

Capacity building: A host of examples emerged during the meeting that illustrate the constraints currently faced by local organizations seeking to implement research or programs that address HIV and MSM. Friedel Dausab of the Rainbow Project described a recent prevalence study in Namibia that relied heavily on the University of Namibia; as a result, it is now unclear whether the Rainbow Project "owns" the data and can use it for its own purposes. In Malawi, CEDEP sought assistance for its study from a number of research organizations but was turned down by most. Lack of local capacity also presents challenges to international organizations seeking to conduct research, as strong local partners may be in short supply. The Population Council experienced such a challenge in Nairobi, where it was difficult to identify MSM who could effectively mobilize other MSM and serve as strong study collaborators.

Local organizations are therefore in need of capacity building to conduct their own research and implement programs, which will foster greater local ownership of findings and outcomes and ensure sustainability. Studies conducted by local organizations are also less likely to be dismissed as part of a non-African, international agenda.

CONCLUSION AND NEXT STEPS

The Overlooked Epidemic meeting was groundbreaking in many ways. It represented the first occasion in which representatives from national AIDS programs convened with researchers, programmers, and advocates to address issues related to HIV among MSM in Africa. The response that the Population Council and Kenya NACC received to the meeting was overwhelming—with double the number of participants expected—suggesting that this long-neglected topic is increasingly receiving the attention it deserves. Particularly encouraging was the strong representation from national HIV programs of 10 countries.[8]

The meeting concluded with the development of a draft consensus statement recommending that national HIV programs:

- Implement national HIV policies that are inclusive of MSM and that empower African health service providers to serve MSM;
- Support research activities that will inform government policy and HIV prevention and treatment programs for MSM;
- Develop strategies to build the capacity of the MSM community, increase public understanding of MSM, and expedite the approval and implementation of MSM-specific prevention, treatment, care, and support programs; and
- Increase involvement of MSM in program planning, implementation, monitoring, and evaluation both to inform program development and to break down social barriers and stigmatization that inhibit communication with MSM.

It is hoped that meeting participants returned to their respective countries equipped with the knowledge and tools to affect change in the HIV programmatic landscape for MSM. Moreover, documentation of the proceedings is intended to foster accountability towards heightened discussion of MSM at the national and regional levels and increased support for programs to improve access to services.

The Population Council and the Kenya NACC will seek opportunities to engage new partners and ensure future progress, for example, by facilitating technical assistance and other support. We will also continue to promote the meeting's outputs at national, regional, and international venues in an effort to garner additional support from policymakers, researchers, advocates, programmers, and donors worldwide.

[8] Burundi, Democratic Republic of Congo, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda, Zambia, and Zanzibar (semi-autonomous).

APPENDIX A: MEETING AGENDA

Wednesday, 14 May 2008: The Evidence in Africa

08:00 – 09:00	Registration

Opening

09:00 – 09:15	Welcome and introduction of participants: Harriet Kongin and Scott Geibel
09:15 – 09:20	Welcome address: Prof. Miriam Were, Chairperson, Kenya National AIDS Control Council, recipient of 2008 Hideyo Noguchi Africa Prize
09:20 – 09:30	Messages from Beatrice Gathirwa, Acting Director, National AIDS Control Council, Kenya; Dr. Ayo Ajayi, Regional Representative for Sub-Saharan Africa, Population Council

Overview of MSM and HIV Issues in Africa: Implications for National HIV Programs

09:30 – 09:45	The need for knowledge: How evidence-based approaches may inform national HIV policies for MSM (Ben Mundia, Kenya National AIDS Control Council)
09:45 – 10:00	The epidemiology of HIV among MSM in Africa: Why it may be important to allocate more resources towards MSM prevention and treatment by national programs (Andrew Seale, UNAIDS; Friedel Dausab, Rainbow Project)
10:00 – 10:15	Discussion
10:15 – 10:30	Tea Break

Panel: Current Evidence and Results

10:30 – 10:45	What is HIV prevalence and incidence among MSM? Evidence from Mombasa and elsewhere in Africa (Dr. Eduard Sanders, KEMRI)
10:45 – 11:00	Results from MSM studies in Senegal, 2001 to 2005 (Dr. Placide Tapsoba, Population Council)
11:00 – 11:15	A snowball survey of 500 MSM in Nairobi, Kenya (Dr. Harriet Birungi, Population Council; W. Onyango-Ouma, Institute for African Studies, University of Nairobi)
11:15 – 11:30	A RDS survey of MSM in Kampala, Uganda (Dr. Phoebe Kajubi, UCSF)
11:30 – 11:45	A RDS survey of MSM in Zanzibar (Dr. Mohammed Dahoma, Zanzibar AIDS Control Programme)
11:45 – 12:00	A time-venue intervention study of male sex workers in Mombasa (Scott Geibel, Population Council)
12:00 – 13:00	Discussion
13:00 – 14:00	Lunch

Panel: Current and Future Research Activities

14:00 – 14:15	A RDS survey of MSM in Lusaka, Zambia (Dr. Elizabeth Measick, CDC)
14:15 – 14:30	MSM research in South Africa: An overview (Dr. Vasu Reddy, HSRC; Dr. Theo Sandfort, University of Columbia; Dr. Tim Lane, UCSF)

14:30 – 14:45	Using RDS for HIV surveillance of MSM and MSW in Africa (Dr. Wolfgang Hladik, CDC)
14:45 – 15:30	Discussion
15:30 – 15:45	Tea Break

Round Table Workshops: How Can National AIDS Programs Assist the Research Process?

15:45 – 16:45	"The first time is the hardest": Obtaining local ethical approvals for MSM studies (Moderator: Dr. Elizabeth Measick)
	Managing the media (Moderator: Dr. Placide Tapsoba)
	"Explain yourselves": How can National AIDS Programs justify MSM programs to government, community, and religious officials? (Moderator: Dr. Mohammed Dahoma)

Summary Presentation of Round Table Sessions

16:45 – 17:00	Obtaining local ethical approvals for MSM studies
17:00 – 17:15	Managing the media
17:15 – 17:30	How can National AIDS Programs justify MSM programs to government, community, and religious officials?

Thursday, 15 May 2008: Developing Programs and Engaging MSM

Panel: Health Services for MSM

9:00 – 9:15	Four years of delivering MSM-friendly services in Nairobi, Kenya. Overview and lessons learned (Dr. Nduku Kilonzo, Liverpool VCT)
9:15 – 9:30	STI and ARV treatment for MSM: Experiences from a vaccine trial cohort in Nairobi, Kenya (Dr. Gaudensia Mutua, Kenya AIDS Vaccine Initiative)
9:30 – 9:45	Scaling up MSM peer education and health worker sensitization interventions: The experience in Coast Province, Kenya (Nzioki Kingola, International Centre for Reproductive Health)
9:45 – 10:00	Delivering comprehensive services to MSM in South Africa (Dawie Nel, OUT)
10:00 – 10:30	Discussion
10:30 – 10:45	Tea Break

Panel: Engaging MSM in HIV Programs – Part 1

10:45 – 11:00	Experiences of MSM in African communities (Allan Muhaari, KEMRI)
11:00 – 11:15	"Identity politics": Challenges MSM face in mobilizing and building capacity to work with HIV programs (Ian Swartz, Rainbow Project)
11:15 – 11:30	Access to HIV services: A human rights perspective (Cary Alan Johnson, IGLHRC)
11:30 – 12:00	Discussion

Panel: Engaging MSM in HIV Programs – Part 2

12:00 – 12:15	Hostility to MSM programming: The example of Uganda (Dr. Paul Semugoma)

12:15 – 12:30	Interacting with health services and policymakers: The experience in Kenya (Peter Njane, GALCK)
12:30 – 12:45	Interacting with researchers: The experience in Malawi (Davison Nyadani, Center for the Development of People)
12:45 – 13:00	Discussion
13:00 – 14:00	Lunch

Case Studies: Targeting MSM in National HIV Plans

14:00 – 14:15	Developing a national HIV plan for MSM in Kenya (Harriet Kongin, Kenya National AIDS Control Council)
14:15 – 14:30	Developing a national HIV plan for MSM in Nigeria (Dr. Alex Ogundipe, Nigeria National Agency for the Control of AIDS)
14:30 – 15:00	Discussion
15:00 – 15:15	Tea Break

Round Table Workshops: Policy, Research, and Programs

15:15 – 16:45	Developing a meeting Consensus Statement: discussion and editing of draft (Moderators: Kenya National AIDS Control Council and Dr. Ayo Ajayi) Priorities for a research and surveillance agenda (Moderators: Dr. Eduard Sanders and Dr. Wolfgang Hladik) Guidelines for HIV health service delivery to MSM in Africa: key recommendations to programs (Moderators: Lorna Dias and Dr. Gaudensia Mutua)

Summary Presentation of Round Table Sessions

16:45 – 17:00	Guidelines for HIV health service delivery to MSM in Africa
17:00 – 17:15	Research and surveillance agenda
17:15 – 17:30	Reading, discussion, and adoption of Consensus Statement

APPENDIX B: LIST OF PARTICIPANTS

Name	Organization	Title
Burundi		
Georges Kanuma	Association pour le Respect et les Droits des Homosexuels	Representative
Dr. Françoise Ndayishimiye	Burundi Conseil National De Lutte Contre Le Sida	Executive Secretary
Thérèse Ntahompagaze	Burundi Conseil National De Lutte Contre Le Sida	Expert chargé de la Prévention au SEP
Democratic Republic of Congo		
Dr. Marcel Kabila	DRC Programme National Multisectotriel de Lutte contre le Sida	Treatment and Care Coordinator
Ghana		
Dr. Ayo Ajayi	Population Council	Regional Director
Dr. Placide Tapsoba	Population Council	Associate
Great Britain		
Adrian Smith	University of Oxford	
Kenya (Mombasa)		
Nzioki Kingola	International Centre for Reproductive Health	Deputy Director
Allan Muhaari	Kenya Medical Research Institute	Counselor
Omari Mwanjama	Kenya National AIDS Control Council	Field Officer
Nicholas Mwema	Stay Alive	Representative
Agnes Rinyiru	International Centre for Reproductive Health	Program Coordinator
Dr. Eduard Sanders	Kenya Medical Research Institute	Program Director
Masila Syengo	International Centre for Reproductive Health	Program Coordinator
Kenya (Nairobi)		
Prof. Omu Anzala	Kenya AIDS Vaccine Initiative	Director
Ann Austen	Constella Futures	Director

Bonnie Bender	International AIDS Vaccine Initiative	Program Manager
Lorna Dias	Liverpool VCT	MSM Services Coordinator
Dr. Alan Ferguson	Constella Futures	Researcher
Beatrice Gathirwa	Kenya National AIDS Control Council	Acting Director
Scott Geibel	Population Council	Associate
Nguru Karugu	Open Society Institute	Consultant
Dr. Nduku Kilonzo	Liverpool VCT	Director
Harriet Kongin	Kenya National AIDS Control Council	Head of Stakeholders Coordination
Elissa Margolin	CDC Kenya	Prevention Program Advisor
Ben Mundia	Kenya National AIDS Control Council	Staff Assistant
Dr. Gaudensia Mutua	Kenya AIDS Vaccine Initiative	Trial Physician
Dr. Zebedee Mwandi	CDC Kenya	Coordinator, Uniformed Services Program
Prof. Elizabeth Ngugi	University of Nairobi Centre for HIV Prevention and Research and Kenya Voluntary Women's Rehabilitation Centre	Director
Peter Njane	Gay and Lesbian Coalition of Kenya	MSM Representative
Angus Parkinson	Liverpool VCT; Gay and Lesbian Coalition of Kenya	Consultant
Norah Omenda	Population Council	Staff Assistant
Jane-Marie Ongolo	United Nations Office on Drugs and Crime	National Project Manager
Cheryl Sonnichsen	USAID Kenya	Senior Advisor for HIV/AIDS
Catherine Theuri	Liverpool VCT	Capacity-building Coordinator
Helen Thomson	International AIDS Vaccine Initiative	Clinical Operations Director
Prof. Miriam Were	Kenya National AIDS Control Council	Chairperson
India		
Dr. Niranjan Saggurti	Population Council	Senior Program Officer

Malawi		
Florence Kayambo	Malawi National AIDS Commission	Head of Policy Development and Support
Davison Nyadane	Center for the Development of People	Representative
Mozambique		
Judite Langa	CDC Mozambique	STI & Vulnerable Populations Advisor
Namibia		
Friedel Dausab	The Rainbow Project	Health Officer
Ian Swartz	The Rainbow Project	Director
Nigeria		
Andrew Karlyn	Population Council	Associate
Dr. Alex Ogundipe	Nigeria National Agency for the Control of AIDS (NACA)	Director, HIV Policy and Strategy
Ifeanyi Kelly Orazulike	Alliance Rights Nigeria	Executive Director
Rwanda		
Elizaphan Hakizimana	Rwanda Conseil National De Lutte Contre Le Sida	Technical Advisor
Dr. Felix Ndagije	CDC Rwanda	Prevention Specialist
Eugene Zimulinda	US Department of Defense	PEPFAR Project Manager
South Africa		
Sibongile Dladla	Perinatal HIV Research Unit	Project Director
Cary Alan Johnson	IGLHRC	Africa Specialist
Dawie Nel	OUT	Director
Dr. Vasu Reddy	Human Sciences Research Council	Research Specialist
Andrew Seale	UNAIDS	Senior Regional Adviser
Tanzania		
Dr. Fatma Mrisho	Tanzania National AIDS Commission	Chairperson
Uganda		
Dr. Wolfgang Hladik	CDC Uganda	Medical Epidemiologist
Dr. Phoebe Kajubi	Institute for Global Health, UCSF	Researcher
Dr. Paul Semugoma	Unaffiliated	Medical Doctor

United States		
Dr. Scott Kellerman	Population Council	Senior Associate
Jeff Stanton	amFAR	MSM Initiative Director
Dr. Waimar Tun	Population Council	Associate
Deborah Weiss	Population Council	Special Assistant
Zanzibar		
Asha Abdullah	Zanzibar AIDS Commission	Executive Director
Dr. Mohammed Dahoma	Zanzibar AIDS Control Programme, Ministry of Health and Social Welfare	Program Director
Jesse Singh	Zanzibar AIDS Control Programme, Ministry of Health and Social Welfare	Peer Educator
Zambia		
Dr. Elizabeth Onjoro Measick	CDC Zambia	Associate Chief of Behavioral Science
Arlene Phiri	Zambia National AIDS Council	Behavior Change Communication Specialist
Chivuli Ukimwi	Society for Family Health	Program Coordinator
Zimbabwe		
Sammy Matsukire	Gays and Lesbians of Zimbabwe	Representative

APPENDIX C: RECOMMENDED READING

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