MSM IN SUB-SAHARAN AFRICA: HEALTH, ACCESS, & HIV

Findings from the 2012 Global Men's Health & Rights (GMHR) Study

The Global Forum on MSM & HIV (MSMGF) African Men for Sexual Health & Rights (AMSHeR)

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ACRONYMS

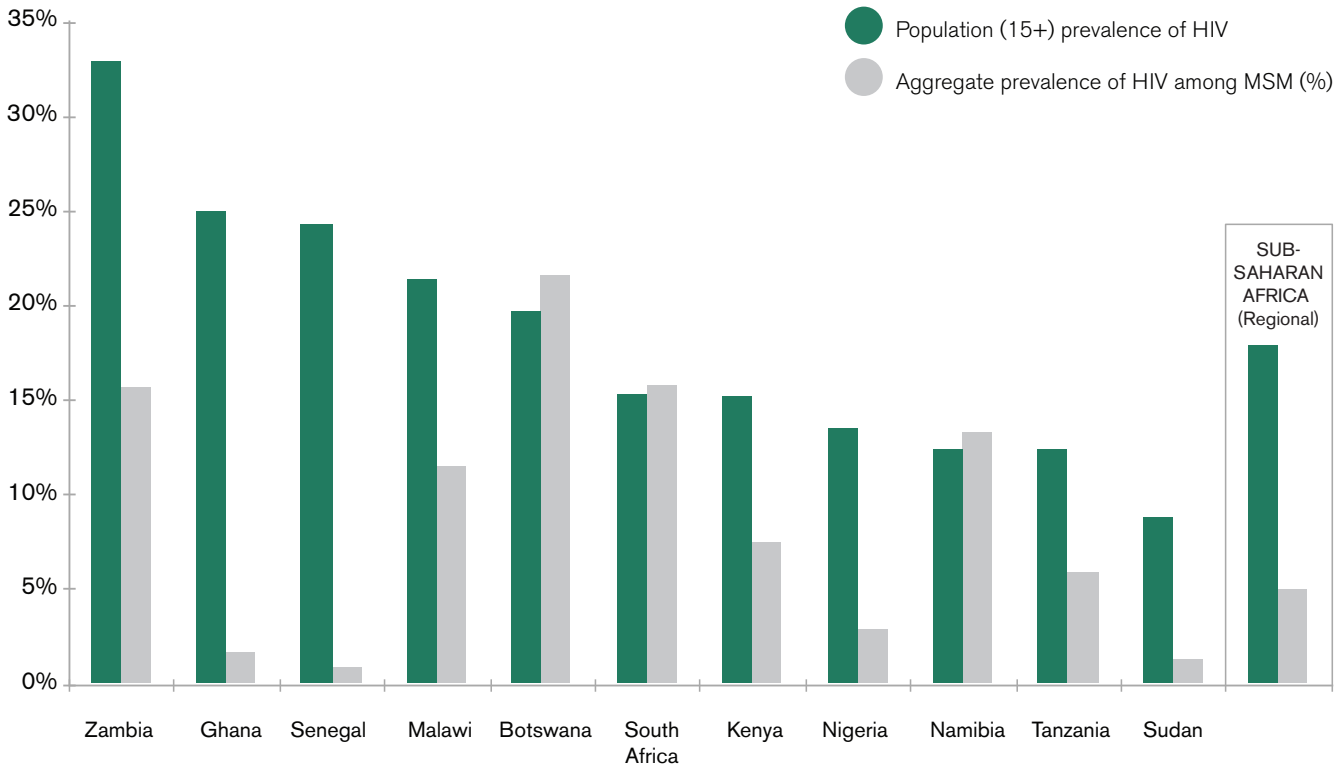
AMSHeR	African Men for Sexual Health and Rights
AOR	Adjusted Odds Ratio
ARV	Antiretroviral Medication
CBO	Community-based Organization
CEDEP	Centre for the Development of People
CEPEHRG	Centre for Popular Education and Human Rights, Ghana
GALCK	Gay and Lesbian Coalition of Kenya
GALZ	Gays & Lesbians of Zimbabwe
GMHR	Global Men's Health and Rights Study
ICARH	International Centre on Advocacy for the Right to Health
LGBT	Lesbian, Gay, Bisexual, and Transgender
MSM	Men Who Have Sex with Men
MSMGF	The Global Forum on MSM and HIV
NSP	National Strategic Plan
TIER	The Initiative for Equal Rights

1. BACKGROUND

In Sub-Saharan Africa, available data show that men who have sex with men (MSM) face high HIV prevalence and incidence. In most countries with reliable data, HIV prevalence among MSM is either greater than or nearly equal to prevalence in the general population. Examining the region as a whole, aggregate HIV prevalence among MSM is more than three times that of the general population (see Figure 1).

FIGURE 1

Aggregate prevalence of HIV among MSM compared to the general population in Sub-Saharan Africa [1-3]



A complex set of determinants drives the HIV pandemic in Sub-Saharan Africa. Among MSM, stigma and discrimination play an important role, as does criminalization of sex between men. Of the 48 countries in Sub-Saharan Africa, 30 criminalize sexual activity between people of the same gender, with sanctions ranging from imprisonment to the death penalty [4]. These laws can severely impact the ability of MSM to access services, the ability of clinics to offer services tailored to the needs of MSM, and the ability of MSM to participate openly in national planning processes that dictate funding and programs [5-7].

In addition to explicit criminalization, stigma and discrimination among healthcare providers can significantly reduce access to services among MSM. According to a recent study of MSM in Malawi, Namibia, and Botswana, few men had ever disclosed same-sex practices to a health professional, and nearly 20% reported being afraid to seek healthcare. The study indicated that fear of seeking health services was strongly associated with experiences of discrimination [8].

Historically, community-based organizations (CBOs) led by lesbian, gay, bisexual, and transgender (LGBT) people have spearheaded the response to HIV among MSM in Sub-Saharan Africa. These organizations initiated and continue to provide nearly all of the HIV services and information tailored to the needs of MSM in the region. They also lead work to address the broader structural determinants of health, including criminalization, stigma, and discrimination, by conducting advocacy for LGBT health and human rights. Despite developing innovative and effective programs and conducting powerful advocacy campaigns, many of these organizations have very little funding or political support as they confront this massive public health crisis.

Historically, community-based organizations (CBOs) led by lesbian, gay, bisexual, and transgender (LGBT) people have spearheaded the response to HIV among MSM in Sub-Saharan Africa.

In recent years, a handful of mainstream professional AIDS service organizations have begun to extend HIV programs to include MSM in the region. Some governments have also started addressing MSM in AIDS National Strategic Plans (NSPs), though often in ways that do not allow for effective HIV programming among MSM [9]. Multilateral agencies have recommended action to curb HIV among MSM in various guidance documents [10, 11], and large global HIV donors like PEPFAR and the Global Fund have made public commitments to fund HIV programming and research among MSM [12, 13]. Despite this apparent progress, recent research suggests that these developments have yet to translate into adequate funding and implementation of MSM programs [14].

As acknowledgement of the HIV epidemics among MSM in Sub-Saharan Africa builds, numerous new initiatives are being developed to scale-up programming for key populations by increasing focus on targeted programs [15, 16]. However, there remain important gaps in the knowledge necessary to ensure successful implementation of programs targeting MSM. Information on access to HIV programs and services among MSM in Sub-Saharan Africa is limited, including information on the barriers and facilitators that impact service access for MSM. There is also limited understanding of how CBOs and community systems can work together with other stakeholders and health systems to form effective and efficient solutions for the delivery of healthcare to MSM [17].

In this context of an uncontrolled epidemic among MSM in Sub-Saharan Africa and new attempts to scale-up MSM-targeted programming, this policy brief aims to address some of these gaps by examining current access to basic HIV prevention and treatment services among MSM in Sub-Saharan Africa. These findings combine the quantitative and qualitative data from the 2012 Global Men's Health and Rights (GMHR) study, and interviews with LGBT-led CBOs across six countries.

The brief concludes with recommendations for action to support the successful scale-up of MSM-targeted HIV programs in the region.

2. METHODS

In 2012, the Global Forum on MSM and HIV (MSMGF) developed and implemented a global multilingual online quantitative survey to identify and explore barriers and facilitators HIV service access for MSM. Respondents were asked to rate the ease with which they could access free or low cost condoms, condom-compatible lubricants, HIV testing, HIV treatment, and MSM-targeted HIV education materials.

In addition to levels of access, the MSMGF Research Team measured factors hypothesized to act as barriers or facilitators of service access using multiple-item scales. These factors included: (i) comfort with health service provider; (ii) past experiences of provider stigma; (iii) past experiences of homophobic violence; (iv) community engagement; (v) connection to gay community; and (vi) perceptions of homophobia. We used multivariable mixed effects logistic regression models to investigate the relationships between each of the barrier and facilitator variables and easy access to health services (adjusting for demographic variables and for mutual confounding between the barriers and facilitator variables). The sample for this sub-analysis was restricted to respondents from Sub-Saharan Africa. The methods of this survey are described in detail elsewhere [18].

Supplementing the global online survey, the MSMGF worked with the African Men for Sexual Health and Rights (AMSHeR) and LGBT-led organizations in South Africa, Kenya, and Nigeria to conduct qualitative focus group discussions with local MSM in five cities: Nairobi, Lagos, Abuja, Pretoria, and Johannesburg. The focus groups engaged in open-ended conversations in 2012 on the factors that affect access to HIV services, grounded in the lived experiences of MSM in their respective cities. We have described the methods and findings of these discussions in a previous report [19]. In this brief, we excerpt key findings.

After collecting and analyzing quantitative and qualitative data and writing a preliminary report, the research team conducted follow-up phone interviews in 2013 regarding CBO work to address HIV among MSM in Ghana, Malawi, Nigeria, South Africa, Uganda, and Zambia (see Table 1). Representatives commented on the development and implementation of a wide range of locally relevant and successful strategies to address the barriers and facilitators revealed by the GMHR, including: (i) relationships between MSM and their health service providers; (ii) homophobia and homophobic violence; and (iii) engagement with the gay community. We describe these interventions in this brief.

TABLE 1

Contributing community-based organizations

Organization	Location
African Men for Sexual Health and Rights (AMSHeR)	Johannesburg, South Africa
Alternatives Cameroun	Douala, Cameroon
Frank and Candy	Kampala, Uganda
Friends of Rainka	Lusaka, Zambia
Gay and Lesbian Coalition of Kenya (GALCK)	Nairobi, Kenya
Gays & Lesbians of Zimbabwe (GALZ)	Harare, Zimbabwe
ISHTAR MSM	Nairobi, Kenya
OUT LGBT Well-Being	Pretoria, South Africa
Out Right Namibia	Windhoek, Namibia
Rainbow Candle Light	Bujumbura, Burundi
The Center for Popular Education and Human Rights, Ghana (CEPEHRG)	Accra, Ghana
The Center for the Development of People (CEDEP)	Blantyre, Malawi
The Initiative for Equal Rights (TIER)	Lagos, Nigeria
The International Center on Advocacy for the Right to Health (ICARH)	Abuja, Nigeria

3. RESULTS

Overall, 6,095 MSM from 169 countries participated in the global online survey between April and August 2012. Of those, 692 (11%) were from Sub-Saharan Africa. Two-thirds of participants in Sub-Saharan Africa were below the age of 30, and 19% of participants in Sub-Saharan Africa reported that they were living with HIV. Participants represented all sub-regions within Sub-Saharan Africa (see Table 2). Seventy-one MSM participated across five focus group discussions. While we did not collect demographic information from focus group participants in an effort to protect the identities of the participants, most focus group participants were between the ages of 20 and 40 years old. Sex workers and men living with HIV were well represented in each of the five groups.

TABLE 2

Geographic breakdown of participants in Sub-Saharan Africa

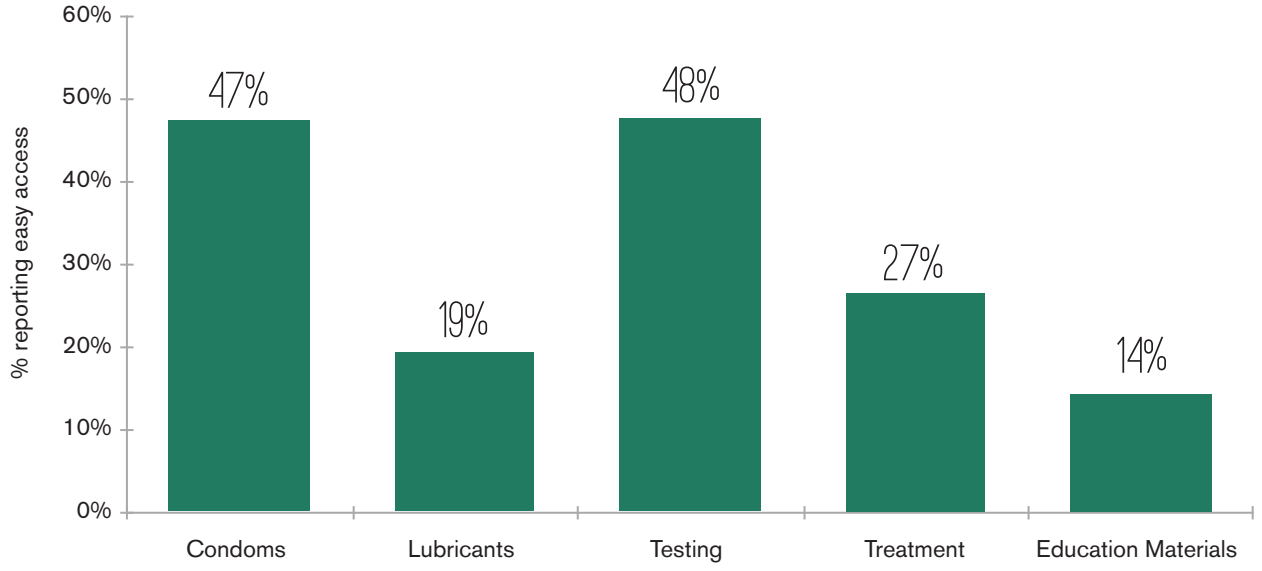
Country	Sub-Region	N	%
South Africa	Southern Africa	152	22%
Nigeria	West Africa	125	18%
Kenya	East Africa	95	14%
Namibia	Southern Africa	81	12%
Cameroon	Central Africa	34	5%
Zimbabwe	Southern Africa	34	5%
Uganda	East Africa	19	3%
Democratic Republic of the Congo	Central Africa	18	3%
Cote d'Ivoire	West Africa	14	2%
Tanzania	East Africa	14	2%
Botswana	Southern Africa	11	2%
Burundi	Central Africa	10	1%
Ghana	West Africa	10	1%
Togo	West Africa	10	1%
Swaziland	Southern Africa	8	1%
Other[1]		57	8%

3.1 Access to HIV Services

Based on the GMHR survey, a low proportion of MSM in Sub-Saharan Africa reported having easy access to free or low cost condoms (47%), condom-compatible lubricants (19%), HIV testing (48%), HIV Treatment (27%), and HIV educational materials targeted at MSM (14%) (see Figure 2).

FIGURE 2

HIV service access among MSM in Sub-Saharan Africa



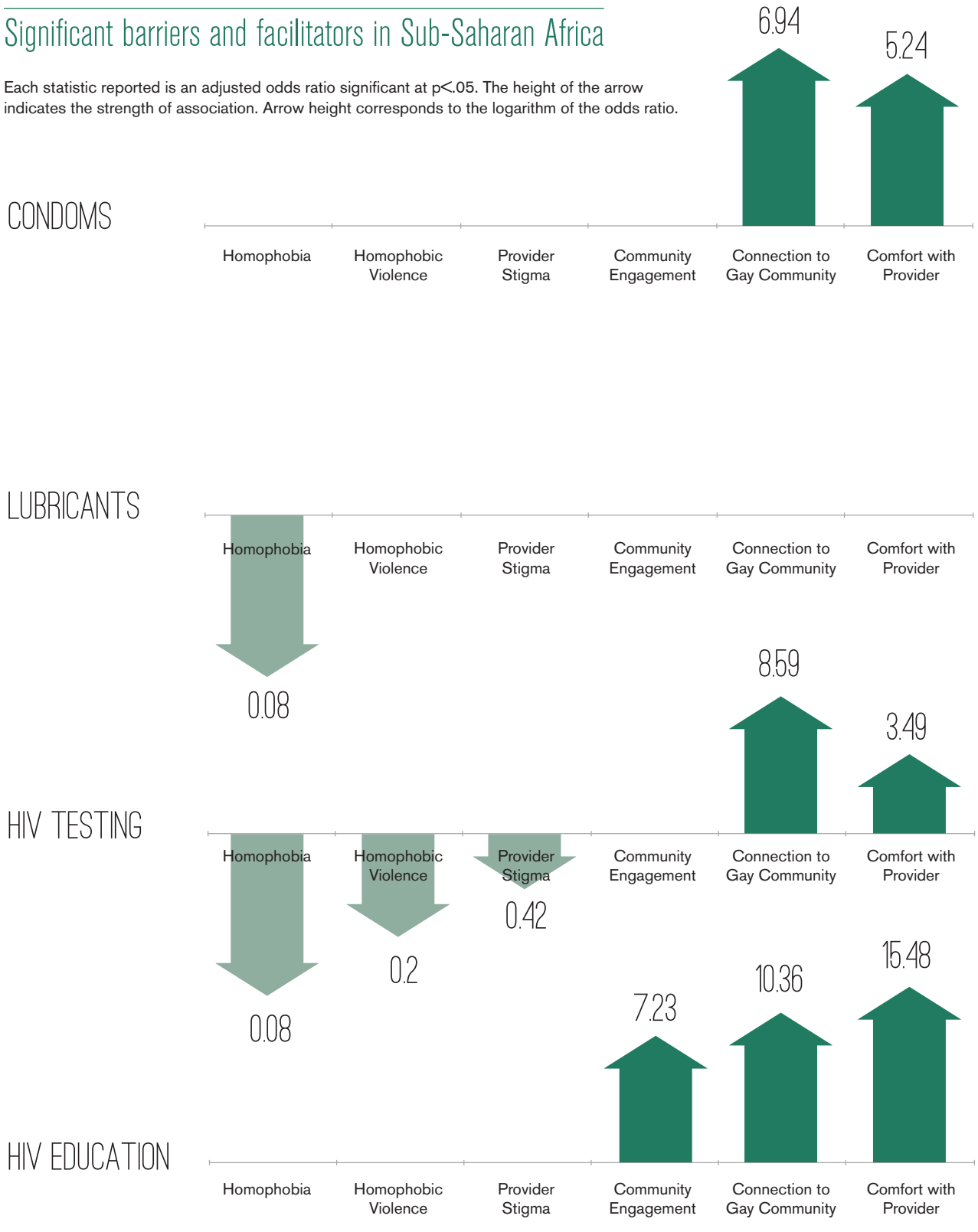
1 Angola, Burkina Faso, Central African Republic, Comoros, Congo, Ethiopia, Guinea, Lesotho, Liberia, Malawi, Mali, Mauritius, Mozambique, Rwanda, Saint Helena, Sao Tome and Principe, Senegal, Sierra Leone, Somalia, Zambia

Both the survey data and the focus group discussions revealed a common set of barriers and facilitators that affect access to basic HIV services among MSM in Sub-Saharan Africa (see Figure 3). These can be grouped into three categories (detailed analysis of these factors is found in Section 3.2): (i) relationship with healthcare providers; (ii) experience of homophobia and homophobic violence in the wider community; and (iii) engagement with the local community of MSM (see Table 5 for complete quantitative results).

FIGURE 3

Significant barriers and facilitators in Sub-Saharan Africa

Each statistic reported is an adjusted odds ratio significant at p<.05. The height of the arrow indicates the strength of association. Arrow height corresponds to the logarithm of the odds ratio.



Additionally, when comparing younger and older MSM, we found that respondents from Sub-Saharan Africa under the age of 30 had more than double the level of access to lubricants (OR = 2.18, 95% CI: [1.23 – 3.86]) compared to respondents over the age of 30. Similarly, respondents under the age of 30 had more than 2.5 times the level of access to HIV education materials (OR=2.60, 95% CI: [1.26 – 5.39]) compared to those over the age of 30. After adjusting for barriers and facilitators and for demographic variables, there was no difference in access to services between MSM in these two age groups. This suggests that the differences between younger and older MSM can be attributed to differences in the levels of barriers and facilitators that these two groups face.

When comparing Sub-Saharan Africa to the other seven world regions represented in the GMHR survey, respondents living in Sub-Saharan Africa reported the highest level of stigma from healthcare providers and the fourth lowest level of comfort with healthcare providers. Respondents from Sub-Saharan Africa also experienced the highest level of homophobic violence and the third-highest level of perceived homophobia. Finally, respondents from Sub-Saharan Africa reported the highest levels of engagement in gay community and connection to gay community.

It is important to note that in different regions barriers and facilitators might affect access to services in different ways. For example, homophobic violence and past experiences of stigma by providers were significantly associated with lower access to HIV testing among MSM living in Sub-Saharan Africa, yet they were not a significant predictor for access to services among the global sample of MSM in the GMHR survey (see Table 3) [10].

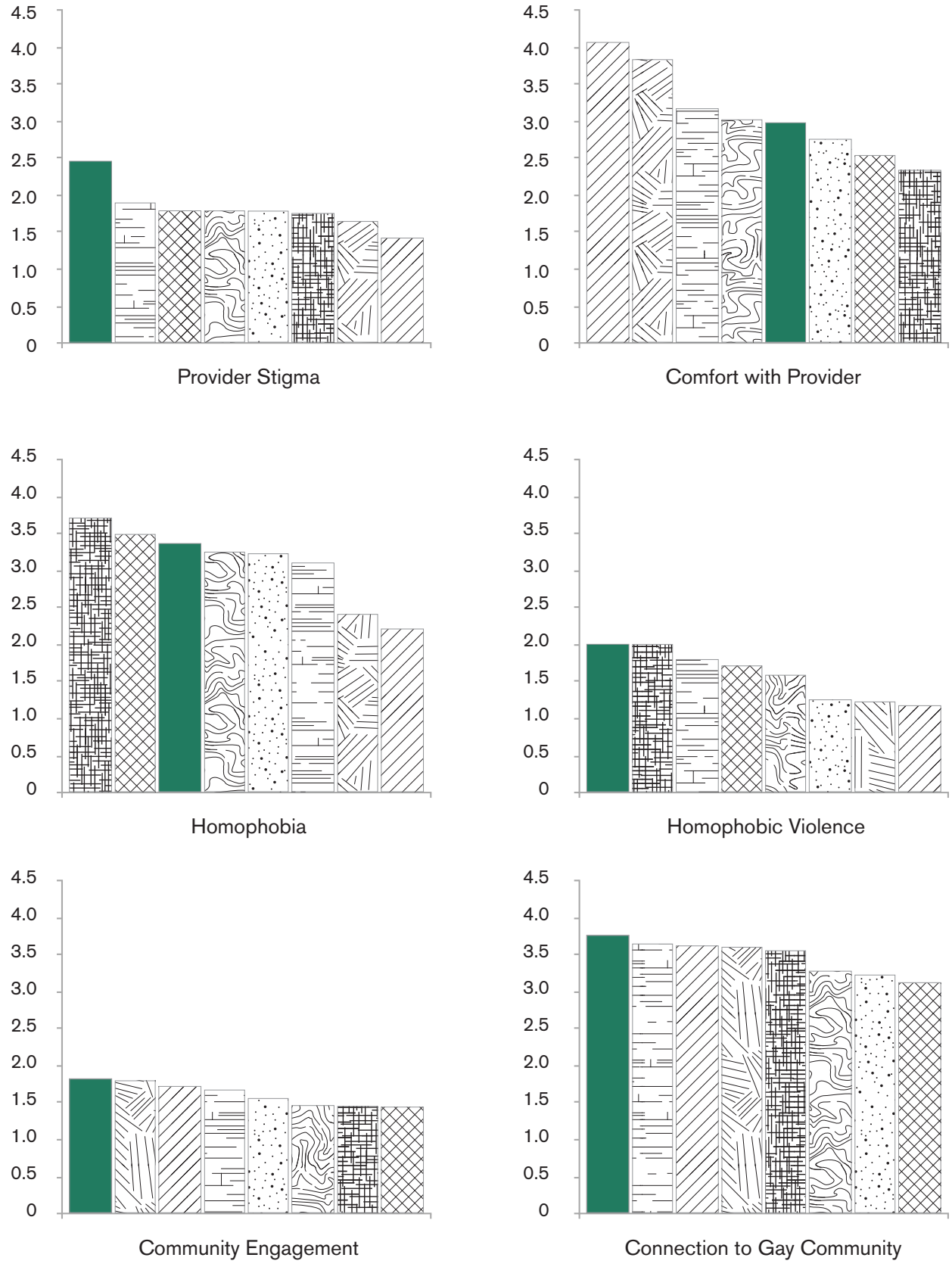
TABLE 3

Predictors of access to services among MSM in Sub-Saharan Africa versus among MSM globally

		Predictors of Access to Condoms	Predictors of Access to Lubricants	Predictors of Access to HIV Testing	Predictors of Access to HIV Education	Predictors of Access to HIV Treatment*
Sub-Saharan Africa	*Barriers*		• Homophobia	• Homophobia • Homophobic violence • Provider stigma		
	Facilitators	• Connection to gay community • Comfort with provider	• Comfort with provider	• Connection to gay community • Comfort with provider	• Community engagement • Connection to gay community • Comfort with provider	• Comfort with provider
Global	*Barriers*	• Homophobia • Provider stigma	• Homophobia	• Homophobia	• Homophobia	• Homophobia
	Facilitators	• Community engagement • Connection to gay community • Comfort with provider	• Community engagement • Connection to gay community • Comfort with provider	• Connection to gay community • Comfort with provider	• Community engagement • Connection to gay community • Comfort with provider	• Comfort with provider

FIGURE 4

Level of barriers and facilitators for Sub-Saharan Africa versus other regions



3.2 Access Issues in Focus

Relationship with Healthcare Providers

Analysis of the quantitative survey data[2] revealed that the relationship between MSM from Sub-Saharan Africa and their healthcare providers was an important predictor of access to HIV services. Compared to MSM who reported the minimum level of comfort with service providers, MSM who reported the maximum level of comfort with service providers were:

- 3.5 times more likely to report easy access to HIV testing
- 5.2 times more likely to report easy access to condoms
- 15.5 times more likely to report easy access to MSM-tailored HIV education materials

Those who reported the highest level of stigma from healthcare providers reported being less than half as likely to report easy access to HIV testing as those who reported the lowest level of stigma from providers.

Focus group discussion participants provided multiple examples of healthcare providers who proselytized against homosexuality rather than providing education regarding HIV prevention or focusing on diagnosing and treating the symptoms presented. Examples included healthcare providers citing biblical excerpts, chastising men for their sexuality, and bringing in other staff to "look at the MSM." Experiencing such frequent mistreatment, participants preferred to protect their sense of self and emotional well-being by avoiding healthcare settings rather than face persistent verbal abuse at the hands of healthcare providers.

Explicit examples of discrimination toward MSM were accompanied by implicit acts of stigma that created environments of shame and fear of exposure. For example, one participant spoke about an experience with a doctor who "spent more time trying to find out if I was MSM than he did in the examination. I knew if I told him, it would not be good for me." The inability of MSM to reveal their sexual lives was related to misdiagnosis, delayed diagnosis, and delayed treatment.

CBOs interviewed in follow-up to the survey employ four main strategies to ensure that community members can access competent and non-stigmatizing health services. These strategies are detailed below.

Community-delivered services

Community-delivered healthcare services, or those provided at a CBO's office or a CBO-run clinic, have helped MSM access services without facing stigma and discrimination, eased the financial burden of accessing HIV services, and provided tailored services that attended to the unique and complex issues faced by MSM.

In South Africa, the organization Out Well-Being delivers general health and mental health services to LGBT people, including a free antiretroviral (ARV) program that accommodates a maximum of 50 clients at any given time. By accessing HIV care and treatment services directly from Out Well-Being, clients are able to avoid stigma, long wait times, and ARV stock-outs associated with government facility care. Taking a holistic approach to health, Out Well-Being assists clients with a wide range of issues in addition to HIV treatment, including coming out, drug use, and relationships.

2 For full quantitative data, see table 6

The Centre for Popular Education on Human Rights Ghana (CEPEHRG) runs a drop-in center in Accra that offers STI diagnosis and treatment, HIV counseling and testing, and psychosocial counseling. CEPHERG began to provide STI medication when they observed that clients would sometimes avoid filling their prescriptions at pharmacies due to experiences of stigma and medication costs. Since the launch of this program, CEPHERG has seen a decrease in the number of new STI infections among local MSM.

In Nigeria, the International Centre on Advocacy for the Right to Health (ICARH) runs an MSM-friendly clinic staffed by local healthcare providers. To build positive relationships between providers who work at the clinic and local MSM, ICARH invites clinic staff to join events they hold for the local MSM community. This has positively impacted relationships between community members and healthcare providers at the clinic. ICARH also holds weekly meetings with community members and clinic staff to identify and address issues that came up over the past week, in an effort to continually improve the quality of care provided to MSM.

Peer-delivered services

In cases where MSM are unwilling or unable to visit an external clinic, some CBOs have instituted peer-delivered services. CEPEHRG deploys community outreach workers to visit MSM in their homes, so clients do not have to pay transportation fees to access condoms, lubricants, testing, and other services including anti-malarial drugs.

Healthcare Provider sensitization

All respondent CBOs reported engaging in activities to sensitize healthcare providers to the needs of MSM.

Over the past year, Out Well-Being partnered with the South African Department of Health to train over 5,000 healthcare providers to provide quality care to MSM clients. Trainings are followed by a structured mentorship program to ensure sustained improvement in skills and attitudes.

In Malawi, the Centre for the Development of People (CEDEP) works to ensure that training of healthcare providers happens sustainably and at scale by engaging policy makers to include MSM issues in the standard curricula used by medical schools. In this way, all graduates can develop skills to competently address the needs of MSM. CEDEP advocates for the medical school curriculum to include such issues as clinical management of MSM (e.g. diagnoses and treatment of STIs), ethics (e.g. confidentiality about sexual identity), and attitudes towards same-sex sexuality.

Client referrals

Helping members to navigate the healthcare system in order to access competent, friendly, and non-stigmatizing healthcare providers is an important function of LGBT-led organizations. Staff at CEPEHRG, the Initiative for Equal Rights (TIER) in Nigeria, and Friends of Rainka in Zambia all refer community members to specific healthcare providers previously sensitized to deliver competent care to MSM. These healthcare providers are often situated in government clinics, which might otherwise not be safe environments for MSM to access services.

There are varying levels of formality with which organizations carry out client referrals. For instance, ICARH in Nigeria has a referral system that includes four healthcare facilities and uses referral forms to communicate between the facilities. After referring a client to a particular site, staff follow-up with healthcare facility contacts to ensure that the client accessed the services that they needed. If the client did not access services, ICARH calls the client to learn what happened. In contrast, CEPERGH, TIER and Friends of Rainka refer clients to individual healthcare providers in specific facilities. These providers will usually have been trained to provide services to MSM.

Beyond referrals, CBOs sometimes take on the additional role of ensuring that community members access care. For example, when Out Well-Being's 50 ARV provision slots are full, they play an overall case management role for clients that access ART in government clinics, providing additional HIV care services including pathology, CD4 count, and adherence counseling and monitoring. In Uganda, Frank and Candy maintains a database of friendly providers in the country to share with other healthcare organizations that serve MSM. In addition, Frank and Candy assists LGBT-led CBOs in different parts of the country to initiate contact with local healthcare providers in order to sensitize them and expand their referral networks.

Homophobia and Homophobic Violence

Perceptions of homophobia in the community, and past experiences of homophobic violence, were negatively related to access to services. Compared to MSM who reported the highest level of violence, those who reported the lowest level of violence were five times more likely to report easy access to HIV testing. Compared to those who reported the highest levels of perceived homophobia, those who reported the lowest levels of perceived homophobia were 12.5 times more likely to report easy access to lubricants and 12.5 times more likely to report easy access to HIV testing.

Focus group participants in Kenya and Nigeria indicated that the criminalization of consensual same-sex sexual conduct provides a pretext for extortion, blackmail, and violence targeting MSM. Even when the law does not explicitly criminalize homosexuality, as in South Africa, high levels of stigma toward MSM and people living with HIV support an environment where extortion, blackmail, and violence are allowed to persist. Participants in all five focus group discussions provided examples of police harassment and brutality, landlord evictions, blackmail, and extortion on the part of strangers, acquaintances, friends, or family members in exchange for keeping the target's sexuality a secret.

Men who participated in the discussions related how factors such as criminalization of homosexuality, police harassment, and cultural norms that favor heterosexuality undermined their ability to sustain or develop close personal relationships. Relationships within their social circles—peers, partners, family members, teachers, health providers, and others— influence the way they engage other individuals, groups, and society, as well as the decisions they make about their own sexual lives. These factors reduce trust, communication, learning opportunities, and social support between men and their familial, social, and health networks. The injury to social and interpersonal relationships leads to poor self-worth, depression and anxiety, and undermines health-seeking behaviors.

With the high prevalence of violence against LGBT people in Sub-Saharan Africa, many CBOs reported responding to cases of violence, albeit in different ways. Some organizations work to change attitudes about homosexuality among the general population, while others work with MSM to help mitigate the risk of violence they face. When incidents of violence do occur, CBOs employ a number of different strategies to respond effectively.

Changing Community Attitudes

Public discussions around sexual orientation are often beset with misinformation and mistaken perceptions of the LGBT community. CEDEP, Frank and Candy, and CEPERGH conduct interventions to improve public discourse about homosexuality, dispel popular myths, and highlight the relationship between societal attitudes and access to much needed services. They also engage policy makers to educate them on the levels and impact of violence faced by LGBT people. CEDEP holds workshops for members of parliament that explain how homophobia impinges on HIV programming and service access. As one respondent commented, "When the lower house signed the same sex marriage prohibition bill, it affected our events immediately. Prior to the date the bill passed, over 500 MSM accessed our services on a monthly basis. After the bill was passed, our number of clients dropped drastically to 150 per month, and most of those people needed to come in to get antiretroviral medication."

CEDEP found it effective to engage religious leaders, HIV organizations, healthcare organizations, and media in radio debates and other forums to ensure that messages sent to the broader community are not homophobic. Over time, these interventions have improved public dialogue on LGBT issues in Malawi. Similarly, CEPEHRG worked to address broader social attitudes toward LGBT people through a community theater program. While the program was successful in creating much needed dialogue, it was difficult to sustain due to a lack of funding and increased risk of violence against members of the theater group given their heighted visibility.

Equipping MSM to Manage Risk of Violence

Because social change can take a significant amount of time, many organizations take measures to protect their local MSM community against sustained threats of violence. ICARH trains local MSM on how to dress in order to minimize the risk of being targeted for violence. CEPRGH provides security training to equip members to assess the risks they face during their daily activities and craft personal strategies to avoid or handle violence.

Responding to Cases of Violence

While most organizations respond to individual cases of violence faced by community members by helping members to identify resources and report or document the cases of violence, some also develop systems to respond to violence through external partnerships. For example, TIER conducts bi-monthly sensitization workshops for security agencies, including the police, the civil defense, and private security companies. TIER initiated this program because security agencies were not only failing to respond to violence faced by LGBT people, they were sometimes responsible for inflicting it. Since the program's launch, TIER has recorded several instances of sensitized security agency members responding effectively to threats of violence against TIER members.

Out Well-Being is part of a National Task Team that works closely with the South African Department of Justice to address violence based on sexual orientation and gender identity. In order to ensure that cases are dealt with appropriately by the criminal justice system, the National Task Team holds monthly meetings with the Department of Justice, the police, and the National Prosecuting Authority to monitor reported cases of hate crimes against LGBT people. The National Task Team has launched a government-sponsored TV advertisement that highlights hate crimes, and provided a toll-free number for the public to use to report hate crimes.

Out Well-being is also part of a civil society violence response program that involves six LGBT organizations across three provinces in South Africa. The program provides case management for people who have experienced violence by assisting in reporting the crime, and providing psychosocial, medical, and legal services.

Engagement with MSM Communities

Engagement in a community of MSM was related positively to service access for MSM in Sub-Saharan Africa. Compared to MSM who reported the lowest level of engagement in social activities with other MSM, those who reported the highest level of engagement were 7.2 times more likely to report easy access to MSM-specific HIV education materials. Compared to those who reported the lowest level of feeling connected to a community of MSM, those who reported the highest level of connection were:

- 6.9 more likely to report easy access to condoms
- 8.6 times more likely to report access to HIV testing
- 10.4 times more likely to report access to MSM-tailored HIV education materials

Participants in focus group discussions noted that the negative consequences of homophobia and homophobic violence in the wider community were mitigated by the existence of safe spaces to meet other MSM, to receive services, and to access competent and comprehensive healthcare. Participants described the CBOs where focus group discussions took place as safe spaces where they could celebrate their true selves, receive respectful and knowledgeable healthcare, and in some cases receive mental health services.

Community engagement, family support, and stable relationships facilitate health and well-being. For example, some focus group participants desire family recognition to help mitigate broader social insults. Most significantly, participants reported that community engagement in safe spaces is a salient factor in ameliorating the loss of family and social connection. Community engagement in safe spaces, such as in the CBOs hosting the focus group discussions, also serves as a respite from hiding, shame, fear, and even violence. The support of other MSM was found to be essential for developing social networks of friends, as well as for learning where to find a trustworthy healthcare provider.

Safe Spaces

Many CBOs act as a space where members of the community meet and socialize in addition to accessing quality services. Friends of Rainka hosts community discussions and outreach events. TIER has a drop-in center where members can access safe sex commodities and health education materials. ICARH has a space where members can watch TV, access the internet, and play games. ICARH also makes the space available for members to use when they want to organize their own events such as birthday parties or anniversary celebrations, which also serve to introduce ICARH to members of the wider LGBT community.

Community Strengthening and Engagement

Beyond creating spaces where MSM can simply come and relax without threat of violence or harassment, the existence of these spaces allows organizations to carry out

activities that strengthen their communities. TIER organizes various activities including skills training for economic development, entrepreneurial training for members who own small businesses, and support groups for MSM living with HIV. CEPERGH organizes games, trips to places of interest, and modeling shows in order to motivate LGBT people with an interest in fashion to participate in community events.

Virtual Spaces

In places where it is dangerous for groups of LGBT people to congregate, CBOs find alternative ways to connect members to each other without compromising security. CEDEP and Frank and Candy both have online spaces on social media sites where members can safely hold discussion with each other. In addition, Frank and Candy hosts the LGBTI Health Africa listserv, which connects activists around the globe to discuss issues that affect LGBT people in Africa.

4. RECOMMENDATIONS

Drawing on findings from the quantitative survey, focus groups, and CBO interviews, this set of recommendations aims to increase access to HIV services among MSM in Sub-Saharan Africa by (i) improving relationships between MSM and healthcare providers and systems, (ii) addressing homophobia and homophobic violence, and (iii) facilitating engagement with gay communities. Designed to be both effective and sustainable, these recommendations apply to the HIV response as a whole, with implications for the collaborative projects carried out by donors, governments, and large international implementing agencies.

1. Make greater and smarter investments in local CBO

Local CBOs have been at the forefront of the fight against HIV among MSM in Sub-Saharan Africa since the beginning of the epidemic, and they are the key to successfully improving access to HIV services among MSM in Sub-Saharan Africa. They benefit from high levels of local knowledge, community trust, community buy-in, and motivation to succeed in achieving health and human rights for their communities. Most importantly, they are led and staffed by members of the target communities, ensuring that capacity investments stay in the community. Making smart investments in local community systems and health systems presents a far more sustainable option compared to investments made in international organizations that depart after projects end, often taking their capacity with them.

Many CBOs have limited access to funding because they are not large enough to accept the large-scale grants that are made by the biggest funders of the HIV response. These grants are often channeled through international implementing organizations, governments, or large mainstream civil society organizations with the hope that some of the funds will be applied towards key population programming. In environments where same-sex sexuality is criminalized and where homophobia has led to the neglect of MSM in the national HIV response, routing money through governments and large mainstream organizations can prevent MSM-led CBOs from participating in planning processes and receiving resources to support vital programs for MSM.

Donors can support access to essential services for MSM by making smart investments in the form of skills development, technical expertise, and organizational capacity building for local CBOs. These investments support the development and sustainable implementation of effective programs tailored to the needs of local MSM. In addition to service provision, CBOs often also serve central advocacy and watchdogging roles, ensuring friendlier environments and more appropriate funding, programs, and policies that support a comprehensive and effective HIV response among MSM.

CBO interview participants identified capacity building needs to further these pivotal roles, including skills to develop winning grant proposals, identifying strong and appropriate project indicators, increasing management capacities, improving report writing and research skills to expand the evidence base and evidence-based planning, and monitoring and evaluating for impact. Community systems strengthening approaches promise to help ensure higher-impact projects and programs that are accountable to community stakeholders [17].

Large donors should provide grant opportunities directly to MSM-led CBOs working on the ground, and the grant opportunities should be designed in such a way that MSM-led CBOs can access them without having funds routed through a third party.

In addition to investing in program implementation costs and capacity-building activities, donors should make adequate investments in the capacity and sustainability of local MSM-led CBOs, including salaries and overhead.

Donors must work with local MSM-led CBOs to shape support so that it addresses real needs, targeted towards organizational sustainability, with clear and measurable outcomes for the organizations receiving assistance.

"It is very possible to develop community groups to gain the level of expert services you need. I have seen it so many times – if you have the right approach and a longer term approach to get your quality outputs, you can do that with community systems. The added advantage is that they are embedded in the community, so they will outlive any grant."

–CBO Interview Participant

2. Integrate Community Systems

In addition to strengthening community-based organizations to deliver services, it is important to integrate community systems by supporting linkages between MSM-led CBOs and different actors in local health systems. As this study shows, MSM in Sub-Saharan Africa report the highest levels of stigma from healthcare providers in the GMHR global sample, and the fourth lowest level of comfort with healthcare providers. Violence and stigma significantly affect access to HIV-related services including testing. MSM-led CBOs are well-suited to build the capacity of mainstream health systems to ensure that they are friendly and competent to meet MSM needs, leveraging enduring government funding of health systems to work sustainably and effectively to improve the quality of MSM services across wide geographic areas.

While vital progress has been made in recognizing the importance of engaging communities and community systems, it must be noted that the appearance of community involvement is far more common than the reality. At this point in the global response, we must prioritize systems to assess meaningful community engagement, with accountability to community members.

Governments should work with local MSM-led CBOs to build linkages between community systems and health systems, including sensitization and competency trainings, designing medical school curricula, and collaboratively developing and implementing shared initiatives.

Donors should prioritize proposals with adequate time and resources dedicated toward meaningful community engagement, including failsafes and assessments that ensure appropriate community engagement.

3. Create an accountable environment conducive to service access

Policies that hinder access to HIV services by and for MSM, including criminalization of sex between men, must be addressed. Such policies undermine the ability of MSM to access services and the ability of community organizations to provide tailored services to MSM. CBO respondents highlighted the challenges that arise when a country's National AIDS Plan prioritizes addressing the epidemic among MSM while the Justice Department continues to treat MSM as criminals.

As shown in this report, LGBT-led CBOs conduct a number of interventions that aim to change the social environment in which MSM live. For decades, monitoring of MSM programs has focused on the numbers of condoms distributed and people put onto treatment. Today, donors and implementers are increasingly acknowledging the importance of addressing human rights, community systems, stigma, violence, and other key factors to the HIV response among MSM when evaluating program impact in Sub-Saharan Africa and globally. However, little work has been done to translate these sentiments into concrete indicators to evaluate success in these areas. Good indicators will provide stakeholders – beneficiaries, implementers, donors – with evidence to further improve access by MSM to HIV-related services.

Additionally, while many donors and implementers collaborate on projects that integrate local MSM-led CBOs to some degree, they rarely support protections against homophobic violence for local CBO partners or their community members. Sub-Saharan Africa reported the highest level of homophobic violence in the GMHR survey, despite the highest level of engagement in MSM communities. Working on projects to promote MSM health and human rights often increases the visibility of community advocates and service providers, which can increase their vulnerability to violence and abuse. Donors and implementers must recognize that these are the realities of this work, and resources must be provided to prevent, mitigate, and address violence against advocates and service providers. This includes but is not limited to trainings and resources for data security, strategies for handling office raids, support for members and clients driven out of their homes, funding to keep lawyers on retainer, and other resources as needed.

When advised to do so by local advocates and community leaders, both donors and large international implementers must leverage their influence and relationships with governments to advocate for policy environments that are more conducive to MSM service access.

Efforts must be made to identify concrete indicators to evaluate program impact in the areas of human rights, community engagement and systems strengthening, stigma and discrimination, violence, and other key factors to the HIV response among MSM.

All projects that address HIV among MSM in countries with high levels of stigma, discrimination, and violence must include adequate provisions to prevent abuse and violence, and to address it when it occurs.

5. CONCLUSION

We have reached a pivotal moment in the response to HIV among MSM in Sub-Saharan Africa, and the opportunity must not be overlooked. Successfully addressing HIV among MSM is challenging in every part of the world, and especially in Sub-Saharan Africa. The region's knowledge and experience are vital to achieving meaningful impact from HIV programming and ending the pandemic. With careful, respectful, and appropriate engagement and investment in CBOs, support of community and health system linkages, and creation of more accessible services, it is finally possible to envision an AIDS-Free future for MSM in Sub-Saharan Africa.

DATA TABLES

Table 4 shows the average score for each of the six barriers and facilitators referred to in this report. The averages are measured for each of the five focus countries in this study brief, and for the five world regions included in the GMHR survey, showing the global average across all respondents.

TABLE 4

Levels of barriers and facilitators in different countries and regions

		Relationship with Provider				Homophobia				Engagement with Community			
		Provider Stigma		comfort with provider		Homophobia		Homophobic Violence		Community Engagement		Connection to Gay Community	
		Score	95% CI	Score	95% CI	Score	95% CI	Score	95% CI	Score	95% CI	Score	95% CI
Countries	**Kenya**	2.44	[2.03 ; 2.84]	3.03	[2.77 ; 3.29]	3.63	[3.49 ; 3.77]	2.54	[2.28 ; 2.79]	1.97	[1.79 ; 2.15]	3.95	[3.74 ; 4.17]
	Namibia	3.63	[3.25 ; 4.02]	2.56	[2.28 ; 2.84]	2.59	[2.47 ; 2.71]	1.66	[1.48 ; 1.83]	1.64	[1.46 ; 1.83]	3.79	[3.58 ; 3.99]
	Nigeria	3.1	[2.78 ; 3.42]	3.04	[2.85 ; 3.23]	3.7	[3.59 ; 3.81]	1.97	[1.77 ; 2.17]	1.84	[1.69 ; 1.99]	3.79	[3.63 ; 3.95]
	South Africa	1.59	[1.37 ; 1.81]	3.37	[3.21 ; 3.53]	2.74	[2.65 ; 2.83]	1.58	[1.44 ; 1.72]	1.77	[1.67 ; 1.87]	3.69	[3.54 ; 3.84]
	Zimbabwe	2.14	[1.46 ; 2.82]	2.75	[2.31 ; 3.19]	3.75	[3.53 ; 3.97]	2.23	[1.83 ; 2.63]	1.77	[1.54 ; 2]	3.63	[3.22 ; 4.03]
Regions	**Asia**	1.79	[1.7 ; 1.87]	2.76	[2.71 ; 2.81]	3.23	[3.2 ; 3.26]	1.26	[1.22 ; 1.29]	1.56	[1.53 ; 1.59]	3.23	[3.17 ; 3.28]
	Caribbean	1.9	[1.61 ; 2.18]	3.17	[2.98 ; 3.36]	3.11	[2.99 ; 3.22]	1.8	[1.62 ; 1.98]	1.67	[1.56 ; 1.79]	3.65	[3.49 ; 3.8]
	Eastern Europe	1.79	[1.68 ; 1.9]	2.54	[2.48 ; 2.6]	3.49	[3.46 ; 3.53]	1.72	[1.65 ; 1.78]	1.44	[1.41 ; 1.48]	3.12	[3.06 ; 3.19]
	Latin America	1.79	[1.67 ; 1.91]	3.02	[2.95 ; 3.08]	3.25	[3.21 ; 3.29]	1.59	[1.53 ; 1.65]	1.46	[1.42 ; 1.5]	3.28	[3.21 ; 3.35]
	Middle East North Africa	1.75	[1.42 ; 2.08]	2.34	[2.08 ; 2.59]	3.71	[3.59 ; 3.84]	2.01	[1.78 ; 2.24]	1.45	[1.35 ; 1.55]	3.55	[3.38 ; 3.73]
	Oceania	1.42	[1.28 ; 1.56]	4.06	[3.97 ; 4.16]	2.21	[2.14 ; 2.28]	1.18	[1.13 ; 1.22]	1.72	[1.66 ; 1.79]	3.62	[3.52 ; 3.72]
	Sub Saharan Africa	2.46	[2.31 ; 2.61]	2.98	[2.89 ; 3.07]	3.37	[3.31 ; 3.43]	2.01	[1.91 ; 2.1]	1.82	[1.76 ; 1.89]	3.76	[3.68 ; 3.84]
	Western Europe	1.65	[1.57 ; 1.72]	3.83	[3.78 ; 3.88]	2.41	[2.38 ; 2.44]	1.23	[1.2 ; 1.25]	1.8	[1.76 ; 1.83]	3.6	[3.55 ; 3.65]
	Global	1.81	[1.77 ; 1.86]	3.13	[3.1 ; 3.16]	3.06	[3.04 ; 3.08]	1.48	[1.46 ; 1.5]	1.63	[1.61 ; 1.64]	3.41	[3.38 ; 3.44]

TABLE 5

Proportion of respondents who reported complete access to key HIV services

		Condoms		Lubricants		HIV Testing		HIV Treatment		Education Materials	
		%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Countries	**Kenya**	54.8	[43.5 ; 65.7]	19.5	[11.6 ; 29.7]	58.8	[47.2 ; 69.6]	43.8	[19.8 ; 70.1]	16.5	[9.1 ; 26.5]
	Zimbabwe	42.3	[23.4 ; 63.1]	19.2	[6.6 ; 39.4]	56	[34.9 ; 75.6]	33.3	[4.3 ; 77.7]	3.8	[0.1 ; 19.6]
	Namibia	34.7	[23.9 ; 46.9]	13.5	[6.7 ; 23.5]	28.8	[18.8 ; 40.6]	20	[0.5 ; 71.6]	17.8	[9.8 ; 28.5]
	Nigeria	40.9	[31.8 ; 50.4]	33.9	[25.3 ; 43.3]	40.4	[31.1 ; 50.2]	10	[2.1 ; 26.5]	27.9	[19.8 ; 37.2]
	South Africa	69	[60.7 ; 76.5]	19.1	[13 ; 26.6]	65	[56.4 ; 72.9]	42.1	[20.3 ; 66.5]	10.9	[6.3 ; 17.4]
Regions	**Asia**	28.5	[26 ; 31.1]	17.4	[15.3 ; 19.7]	24.9	[22.4 ; 27.6]	39.2	[29.7 ; 49.4]	5.9	[4.6 ; 7.5]
	Caribbean	40	[30.6 ; 50]	19.2	[12.2 ; 28.1]	42.6	[32.8 ; 52.8]	73.3	[44.9 ; 92.2]	11.9	[6.3 ; 19.8]
	Eastern Europe	25.2	[22.2 ; 28.5]	17.6	[14.9 ; 20.5]	28.1	[24.9 ; 31.5]	40.5	[29.3 ; 52.6]	9.2	[7.2 ; 11.6]
	Latin America	29.9	[26.5 ; 33.4]	9.3	[7.2 ; 11.7]	16	[13.2 ; 19]	26.5	[18.8 ; 35.5]	3.5	[2.2 ; 5.3]
	Middle East North Africa	30.3	[21.5 ; 40.4]	16.2	[9.5 ; 24.9]	29.7	[20.5 ; 40.2]	42.9	[9.9 ; 81.6]	2.4	[0.3 ; 8.3]
	Oceania	55.1	[48.6 ; 61.4]	50.6	[44.2 ; 57.1]	67.4	[61 ; 73.3]	63.6	[45.1 ; 79.6]	40.4	[34.1 ; 47]
	Sub Saharan Africa	47.4	[43.3 ; 51.6]	19.4	[16.2 ; 22.8]	47.6	[43.4 ; 51.9]	26.5	[18.1 ; 36.4]	14.4	[11.5 ; 17.6]
	Western Europe	46.5	[43.6 ; 49.4]	32.5	[29.7 ; 35.3]	57.1	[54.2 ; 60.1]	49.7	[43.7 ; 55.6]	31.6	[28.8 ; 34.5]
	Global	36.3	[35 ; 37.7]	21.8	[20.6 ; 23]	37.3	[35.9 ; 38.7]	41.5	[37.9 ; 45.2]	15.2	[14.2 ; 16.3]

TABLE 6

Relationships between barriers and facilitators and complete access to services among MSM in Sub-Saharan Africa

	Condoms			Lubricants			HIV Testing			HIV Education			HIV Treatment**		
	AOR*	95% CI	p	AOR	95% CI	p	AOR	95% CI	p	AOR	95% CI	P	AOR	95% CI	p
Homophobia	0.47	[0.12 – 1.87]	0.285	0.08	[0.01 – 0.63]	0.017	0.08	[0.01 – 0.5]	0.007	1.08	[0.11 – 10.7]	0.947	0.04	[0 – 3.04]	0.142
Homophobic Violence	0.81	[0.31 – 2.14]	0.676	3.24	[0.86 – 12.16]	0.082	0.20	[0.07 – 0.6]	0.004	1.54	[0.37 – 6.35]	0.554	0.70	[0.04 – 11.39]	0.802
Provider stigma	0.59	[0.32 – 1.08]	0.085	1.17	[0.49 – 2.77]	0.722	0.42	[0.21 – 0.82]	0.011	0.71	[0.27 – 1.89]	0.495	0.68	[0.09 – 5.06]	0.703
Community Engagement	1.13	[0.29 – 4.4]	0.86	1.76	[0.3 – 10.26]	0.532	0.50	[0.11 – 2.34]	0.381	7.23	[1.05 – 49.59]	0.044	1.74	[0.04 – 79.75]	0.776
Connection to Gay Community	6.94	[2.21 – 21.81]	0.001	4.79	[0.96 – 23.94]	0.056	8.59	[2.56 – 28.74]	<0.001	10.36	[1.5 – 71.79]	0.018	7.64	[0.25 – 238.08]	0.246
Comfort with Provider	5.24	[1.95 – 14.11]	0.001	3.48	[0.9 – 13.48]	0.072	3.49	[1.19 – 10.21]	0.022	15.48	[3.18 – 75.39]	0.001	177.70	[2.49 – 12697.48]	0.017

*These Adjusted Odds Ratios (AOR) compare the highest possible level of each predictor to the lowest possible level

**Due to the small sample-size of MSM living with HIV in Sub-Saharan Africa, estimates for the relationship between barriers/facilitators and access to HIV treatment show very wide confidence intervals.

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The Global Forum on MSM & HIV (MSMGF) is a coalition of advocates working to ensure an effective response to HIV among MSM. Our coalition includes a wide range of people, including HIV-positive and HIV-negative gay men directly affected by the HIV epidemic, and other experts in health, human rights, research, and policy work. What we share is our willingness to step forward and act to address the lack of HIV responses targeted to MSM, end AIDS, and promote health and rights for all. We also share a particular concern for the health and rights of gay men/MSM who: are living with HIV; are young; are from low and middle income countries; are poor; are migrant; belong to racial/ethnic minority or indigenous communities; engage in sex work; use drugs; and/or identify as transgender.

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