Responding to the HIV-related needs of MSM in Africa

WORKSHOP GUIDE
A GUIDE TO FACILITATING A CONSULTATION WORKSHOP WITH STAKEHOLDERS
Acknowledgements

This facilitator’s guide draws on the experiences of the International HIV/AIDS Alliance and its partners in developing approaches to prevention work with men who have sex with men.

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Front cover:
Top photo: A member of a social and activist group for gay men in Senegal. In Senegal, homosexuality is considered a moral crime punishable by up to five years in prison and a $3,000 fine. Discussion groups provide a forum to discuss HIV prevention strategies and other health concerns in confidence and away from judgement. © 2007 Nell Freeman for the Alliance

Bottom photo: Flip chart from a social and discussion group for MSM raising concerns regarding exposure, Senegal. © 2007 Nell Freeman for the Alliance

Participant at a discussion group, Senegal. © 2007 Nell Freeman for the Alliance
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Responding to the HIV-related needs of MSM in Africa
Introduction

This guide has been produced for people who want to improve the response to the HIV-related needs of men who have sex with men (MSM) in Africa. The guide will help you to facilitate a participatory reflection meeting with key stakeholders who are responsible for improving local and national responses to HIV among MSM.

The guide provides a set of activities for you to be able to facilitate this meeting together with basic information to increase understanding about MSM and, in particular, MSM and the HIV epidemic.

The guide is designed to help participants:
- explore their own attitudes and feelings about working with MSM
- identify what is being done already, or has been done elsewhere, that could usefully be adapted to their local setting, and
- identify and plan a course of action in response to local situations.

Why is decision makers’ participation and stakeholder collaboration so important?

In many countries in Africa sex between men is still a sensitive issue; in fact in most African countries it is still illegal and in some, sex between men carries the death penalty. To develop effective HIV responses it is essential that MSM are actively involved in the design and planning of interventions and the evaluation of their impact. Therefore, responding to the needs of MSM presents numerous challenges, not least because the active participation of MSM is often blocked in countries by key decision makers and stakeholders at both the national and local levels. Many have little exposure to MSM and often have opinions, values, religious beliefs and prejudices that hinder their capacity to support effective responses that are grounded in public health and human rights principles.

In order to respond to this challenge, it is important to ensure that decision makers understand the HIV-related health needs of MSM and also appreciate the importance of adequately addressing their needs in developing and implementing an effective evidence-based HIV response.

Collaboration is also important because it can help to:
- identify critical gaps and needs
- learn from the experience of others (both positive and negative), and
- avoid duplication of activities and efforts.
Why run a workshop on MSM issues?

The overall purpose of this guide is to contribute to the development of technically-sound interventions, based on public health and human rights principles, that respond to local needs of MSM. With this overall purpose, local and national workshops on MSM can help with the below.

MSM workshops can help to:

• provide opportunities for a range of stakeholders to clarify their own feelings and attitudes towards MSM
• improve communication among stakeholders who share an interest in responding to the needs of MSM
• create an opportunity for MSM to articulate their needs and show how they can be effective participants in the response rather than passive recipients
• clarify what is known about the situation for MSM in your country e.g. services available, social norms towards MSM, the legal situation and how it is implemented in practice
• develop an understanding of who is doing what work (if any) with MSM
• identify critical gaps e.g. in contextual knowledge and essential services
• establish a platform for future advocacy
• argue for appropriate funding to be made available, and
• create an ongoing network and partnership, with opportunities for sharing resources.

Workshop structure

The overall objectives of the workshop are:

• to increase understanding of the specific needs of MSM within the context of the HIV epidemic
• to increase knowledge of effective and promising responses to addressing the HIV-related needs of MSM, and
• to identify key priorities, related actions and appropriate partners in responding to the HIV-related needs of MSM within the overall framework of the national response.

The main elements of each session are shown in the table on the next page. Each session is expected to take half a day, so it will take three days to complete all the activities and achieve all the objectives.
## SESSION PLAN

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Ideally, the workshop sessions will be run over three consecutive days in a residential setting. However, as this is not always possible, the workshop is divided into five sessions, which can take place over a more extended period of time — for example, as any of the following:

- six separate half-day sessions
- two days with a one-day follow-up, or
- three separate days.

Each session has its own specific objective, and includes one or more activities. There is a logical sequence to the sessions and their objectives, so it is essential to follow them in order.

Each session is expected to last half a day except the response planning activity which is more time consuming. It takes a whole day to complete and can be divided into a morning and afternoon session or completed over two half-days.
Facilitating the workshop

The workshop should be led by people who are experienced in working with MSM and are comfortable talking about sexuality and sexual behaviour. Ideally, the facilitation team will include MSM. Whatever the composition of the team, it is essential that its members are fully committed to respecting the rights and dignity of MSM and to challenging stigma and discrimination.

Facilitators should have familiarised themselves thoroughly with all the materials to be used in the workshop, including the handouts presented in Part 2 and the background information in Part 3.

The effectiveness of the sessions will be maximised by ensuring that the right people attend the workshop, and by preparing the logistics and materials in advance.

Who should attend?
The workshop is designed for individuals and representatives of key groups involved in responding to the needs of MSM. Who these are will vary from one country to the next, and will need to take into consideration cultural and political sensitivities. However, participants are likely to include some or all of the below.

Likely participants may come from:
- national and international non-governmental and community-based organisations (NGOs and CBOs), including those representing or working with MSM and other sexual minority and women’s rights groups
- HIV organisations
- human rights organisations
- religious and social organisations that promote caring and inclusion
- government agencies such as national AIDS bodies and the ministry of health, and
- United Nations (UN) agencies such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Development Programme (UNDP).
Planning the session

The guide includes detailed instructions and tips for facilitators. For each session, you will find the following information:

- what the activity is
- why you should use it
- how long it should take
- what materials are required (to enable you to prepare your photocopying), and
- facilitator’s notes (step-by-step guidance on conducting the activity).

Detailed guidance is provided for each workshop session. Some require you to prepare materials in advance (e.g. photocopying resources) while others require participants to prepare presentations in between sessions. They will need sufficient advance notice to do this.

Initially, it is suggested that you read through the whole guide and note any preparations you need to make for each session.

Evaluating the workshop

The final handout (Handout 9) is a workshop evaluation form. This includes numerical scores and space for comments. Resources permitting, these should be collated and a brief report prepared for sponsors, participants and facilitators, in order to share feedback on the experience of the workshop and identify improvements that can be made in future events.
Part 1 Workshop sessions
Session 1 Workshop introduction

Key objectives

- To introduce participants and facilitators, and set the tone of the workshop
- To articulate thoughts and feelings about working with men who have sex with men.

Activities

1.1 Introduction and ground rules
1.2 Developing a common understanding
1.3 Values continuum: thoughts and feelings
1.4 Feel, think, do
1.5 Preparing for Session 2
1.1 Introduction and ground rules

What is this activity?
This activity asks people to introduce themselves, familiarises them with the planned programme, and invites them to make a contract about how they will work together.

Why use it?
This activity creates a collaborative and friendly atmosphere for the rest of the workshop.

How long does it take?
Up to one hour.

Materials you need

**Handout 1: Workshop plan**, for each participant.

**Handout 2: Suggested ground rules**, for each participant.

A sheet of flipchart paper with the proposed ground rules written on it and displayed where everyone can read them (or PowerPoint and a projector, if you have access to them).

A sheet of flipchart paper with the proposed workshop plan written on it and displayed where everyone can read it.

Facilitator's notes
1. Briefly welcome the participants, and introduce yourselves.

2. Provide a concise overview of the workshop plan and its objectives.

3. Ask participants to introduce themselves by stating the name they wish to be known by during the workshop and one word to describe how they feel about being here.

4. Attend to any necessary housekeeping arrangements, such as details of breaks, reimbursement of travel expenses, health and safety arrangements such as fire exits, and accommodation issues if the workshop is residential.

5. Distribute **Handout 1: Workshop plan**.

6. Explain that this session will focus on the first objective of the workshop.

7. Distribute **Handout 2: Suggested ground rules**.

8. Explain that the issue of MSM is potentially sensitive, and that in order to contribute to discussions people will need to feel safe enough to express their thoughts and feelings, and secure in the knowledge that their confidentiality will be respected.

9. Ask participants if they agree to the ground rules, and whether there are any they would like to change or add. Then, amend the rules as appropriate.

Suggested ground rules

- We will value difference (of opinion and experience).
- We will keep everything shared within this workshop confidential.
- We will arrive on time, to show respect to other people in the group.
- We will seek to practice active listening.
- We will switch off mobile phones and laptops during sessions.
- Any others…?
1.2 Developing a common understanding

**What is this activity?**
This activity is a quiz that covers basic information about MSM. Before you run the activity, familiarise yourself with the basic facts, set out in Resource 1: Glossary of sexual identity and behaviour, and Resource 2: Understanding men who have sex with men.

**Why use it?**
We recommend that all groups using the activities in this guide begin by doing this activity. It reveals participants’ current awareness of common terms relating to MSM issues, and helps to establish shared understanding of commonly used terms. This is important in creating a basic common understanding about MSM that will be essential for the future work of the group.

**How long does it take?**
45–60 minutes.

**Materials you need**
*Handout 3: Sexuality quiz, for each participant.*
*Resource 1: Glossary of sexual identity and behaviour, for each participant.*
*Resource 2: Understanding men who have sex with men, for each participant.*

**Facilitator’s notes**
1. Explain that you will now do an activity that allows participants to share knowledge about MSM. This is not a test — it is a tool to prompt discussion.

2. Give each participant a copy of Handout 3, and ask them to take two minutes to complete it without discussing their answers with one another.

3. If there are more than 12–15 participants in the group, divide them into smaller groups, each led by a separate facilitator. Otherwise, the discussion can be conducted in plenary.

4. Take 30–45 minutes to discuss responses to each question, referring as necessary to Resources 1 and 2. Distribute copies of these resources to participants at the end of the activity.

5. In plenary, ask participants to share anything they learned about themselves from the activity.

Depending on how long the quiz takes, you may have time for only one of the two remaining activities for this session. You can always use the other activity at the beginning of a subsequent session.
1.3 Values continuum: thoughts and feelings

What is this activity?
This activity gets participants moving around the room to explore values towards MSM.

Why use it?
To encourage participants to explore their own values and attitudes towards MSM, and to learn about the values and attitudes of others.

How long does it take?
30 minutes.

Materials you need
Two large pieces of paper marked ‘Agree’ and ‘Disagree’, displayed at either end of the room.

Facilitator’s notes
1. Make sure there is enough space for participants to walk freely from one end of the room the other.

2. Place a large piece of paper headed ‘Agree’ and another with ‘Disagree’ on the wall at each end of the room.

3. Tell participants that you will read out a statement and they should then go to the end of the room that best represents their response. If they are not sure, they should stand in the middle of the room, or in the direction of the answer that most describes their response.

4. They should then talk to someone else in the same position and take a minute or two to explain why they have placed themselves where they are there.

5. After you have called out the first statement and participants have placed themselves accordingly, ask, in turn, for a volunteer from each end of the room to explain to the group why they are standing where they are. Ask others to share their response before moving on to the next statement.

6. In plenary, ask participants:
   - What did you learn from the activity?
   - What did you learn about yourself?

Examples of statements
‘Gay and MSM mean the same thing’
‘Homosexuality is a medical condition that can be treated’
‘Homosexuality should be discouraged’
1.4 Feel, think, do

**What is this activity?**
Participants listen to a set of statements before writing their responses to each, and discussing them.

**Why use it?**
To help participants understand that responses to challenging situations are seldom based solely on rational arguments — they also include an emotional element. This may play an equal, or greater, role in determining their response to a situation.

**How long does it take?**
30–45 minutes.

**Materials you need**
Paper and pens for participants.

**Facilitator’s notes**

1. Divide participants into groups of three or four.
2. Ask each participant to take a pen and piece of paper.
3. Give the following instructions:

   Listen to each of scenarios I am about to read out. Then, without discussing your responses with anyone else, write down:
   - what you feel about the situation
   - what you think about the situation, and
   - what you would do about it.

   When I have read out all the scenarios, discuss your responses in turn for 20 minutes before getting together again in plenary.

4. In plenary, ask participants to discuss their responses to the following questions:
   - What were the main differences between what you thought and what you felt?
   - Which was more important in determining what you would do?
   - Whose interests were you most concerned about in each scenario?
   - What did you learn from the activity?
   - What did you learn about yourself?

**Suggested scenarios**

You think your 16-year-old child might be gay and that he is being bullied because of it.

A friend tells you he was the victim of a vicious homophobic assault by the police.

A family member tells you (and only you) that he thinks he is gay.

In a meeting about MSM, your colleagues make homophobic comments and jokes.

The government announces that citizens have a duty to report anyone they know or believe to be an MSM.
1.5 Preparing for Session 2

In Session 2, participants will share their knowledge about the situation concerning MSM within their community, geographical region or country.

To do this, each participant will come to the session with a prepared 15-minute presentation. The presentation should address as many of the questions detailed in Handout 4: Participant presentations as possible, so distribute the handout to prepare them for the task.
Session 2 The evidence base and key issues

Key objective

- To demonstrate an understanding of the key issues relating to men who have sex with men within the context of the HIV epidemic.

Activities

2.1 Presentation: MSM and HIV in Africa
2.2 Participant presentations
2.1 Presentation: MSM and HIV in Africa

What is this activity?
The activity consists of a facilitator presentation of the key issues relating to MSM and HIV in Africa, based on the available data.

Why use it?
To share available information and provide a common starting point for subsequent discussions.

How long does it take?
60–90 minutes, including the presentation and subsequent discussion.

Materials you need
Resource 3: MSM and HIV in Africa, given to each participant before the presentation begins.

Facilitator’s notes

1. Ensure you are familiar with the presentation before you deliver it. Feel free to adapt it to your own style, but do retain the original content.

2. Facilitate a session of questions and answers following the presentation, encouraging participants to feel able to ask whatever questions they wish.
2.2 Participant presentations

What is this activity?
Participants share their prepared responses to the set of questions given to them at the end of session 2.1.

Why use it?
To give participants an opportunity to share their local knowledge and thus contribute to the knowledge base of the whole group.

How long does it take?
This will be determined by the number of presentations to be made, but allow for 15 minutes per participant including any questions.

Materials you need
Handout 4: Participant presentations (which should have been given to participants at the beginning of Session 2).
Resource 4: Questions for participant presentations, for each participant.

Facilitator's notes
1. Ask participants to make their presentations in turn.
2. Explain that in order to ensure that everyone has the chance to make their presentation you will be strict about sticking to the agreed time allocated.
3. If possible, copy the presentations and distribute them to all the participants.
4. Encourage participants to continue the discussions during breaks.
Session 3 Principles and strategies

Key objective

- To identify key principles and promising strategies for working with men who have sex with men, together with common barriers and ways of overcoming these.

Activities

3.1 Presentation: Key principles and strategies
3.2 Exercise: Prevention strategies
3.1 Presentation: Key principles and strategies

What is this activity?
The activity consists of a facilitator presentation about key principles and strategies for addressing the HIV-related needs of MSM in Africa.

Why use it?
To share available information and provide a common starting point for subsequent discussions.

How long does it take?
90 minutes, including the subsequent discussion.

Materials you need
Resource 5: Key principles and strategies. Copy and distribute to all participants before the presentation begins.

Facilitator's notes
1. Ensure you are familiar with the presentation before you deliver it, and practice with a colleague. Feel free to adapt it to make it your own presentation while retaining the original content.

2. After the presentation, facilitate a session of questions and answers, encouraging participants to feel able to ask whatever questions they wish.
3.2 Prevention strategies

What is this activity?
The activity involves participants breaking into four groups and each group thinking through possible interventions to increase HIV prevention among MSM at different levels, i.e. for the individual, to affect positive change in social norms, to improve access of MSM to services, and to affect structural change by advocacy and other initiatives to increase attention and funding for MSM and mitigate the impact of laws and policies that may inhibit effective programme responses to the needs of MSM.

Why use it?
This helps participants consider the kinds of interventions that can be used to affect positive change at different levels, and see how similar interventions can affect change at multiple levels. It also creates an opportunity for participants to share their own experience and knowledge.

How long does it take?
90 minutes (30–45 minutes in small groups), including feedback in plenary and subsequent discussion.

Materials you need
A flipchart.

Facilitator’s notes
1. Encourage participants to consider the evidence upon which the intervention they propose is based and why they think it will have the desired effect.

2. This is a quick exercise and participants should not worry if they are only able to come up with a few examples as they will have time to think through possible interventions in the next session.

3. Once all the groups have completed the exercise, they feedback in turn to the group.
Session 4 Planning responses

Key objective

- To apply learning acquired so far through planning responses to scenarios.

Activity

4.1 Responding to scenarios
4.1 Responding to scenarios

**What is this activity?**
In small groups, participants plan comprehensive responses to one of two different illustrative scenarios.

**Why use it?**
To give participants practice in thinking through and planning a comprehensive response to a specific scenario, and to receive critical feedback on their work before they make their ‘real’ action plans.

**How long does it take?**
One full day (two sessions).

**Materials you need**
- Handout 5: Country scenario 1, or Handout 6: Country scenario 2, for each participant.
- Handout 7: Change framework, for each participant.

**Facilitator’s notes**

**SESSION 1**

1. Explain to participants that the next two sessions will be spent working in small groups and planning comprehensive responses to one of two imaginary scenarios. This will give them the opportunity to experience working together, and to receive feedback from their peers on their plans before they formulate their real action plans in the final session of the workshop.

2. Divide participants into small groups of between three and six participants.

3. Remind participants about the Change Framework that was introduced in the presentation ‘Key principles and strategies’ in Session 3. This is a framework to help participants think logically through proposed interventions to ensure they have the maximum chance of having the desired impact before they are implemented.

4. Provide each member of each group with a copy of the scenario they will be working on (Handout 5 or 6).

5. Talk through the instructions for the country scenarios and take questions for clarification. Explain that the task for the following two sessions is to use Handout 7 as a template for planning a comprehensive response to the situation described in the scenario.

6. Encourage participants to think through the kind of interventions that may be needed to respond to each of the following four levels of intervention:
   - Individual household
   - social-normative
   - service provision
   - structural.
SESSION 2

7. Give each small group approximately 20–30 minutes during the second session to present their work to the remainder of the group and receive feedback on their work. Groups will need to think about how they wish to present their work — for example, using PowerPoint, on a flipchart or through role play.

8. The facilitators will act as consultants throughout the sessions, and will be available to the small groups to help them in their work.

9. When you plan the structure for these two sessions, make sure that all groups have the same amount of time to present their work.

10. At least one of the facilitators should take detailed notes during the presentations, so that you can provide feedback if participants would like you to do so.
**Session 5** Action planning

**Key objectives**

- To develop SMART action plans (Specific, Measurable, Achievable, Realistic and Timely)
- To give time to evaluate and close the workshop.

**Activities**

5.1  Action planning
5.2  Workshop evaluation
5.3  Closing activity
5.1 Action planning

What is this activity?
An opportunity for participants to plan how they are going to use the learning from this workshop when they return home and back to work.

Why use it?
Action planning helps participants to make plans that are SMART (Specific, Measurable, Achievable, Realistic and Timely).

How long does it take?
1–2 hours.

Materials you need
Handout 8: Action planning matrix, for each participant.

Facilitator’s notes

1. Explain that the workshop is coming to an end, and that it is time to think ahead as to how participants can incorporate their learning into their own work when they return home.

2. Ask participants to plan how they are going to use the learning alone initially before getting into pairs or trios to check and challenge each other’s plans.

3. When the plans are completed, ask participants to copy them onto flipchart paper and display them on the walls around the room.

4. Then, ask participants to walk around the room and consider each other’s plans, asking questions for clarification as necessary.

5. Resources permitting, you may find it useful to copy all the plans and distribute them to participants.
5.2 Workshop evaluation

What is this activity?
Participants complete a workshop evaluation form, which is then collated and distributed to sponsor, facilitators and participants.

Why use it?
To receive feedback from participants about their experience of the workshop. This can help when assessing the usefulness of specific sessions and the overall effectiveness of the workshop.

How long does it take?
20–30 minutes.

Materials you need
Handout 9: Workshop evaluation form, for each participant.

Facilitator's notes

1. Explain that you will now distribute a workshop evaluation form, which will help to assess the usefulness of the workshop. This will be anonymous. Participants should not write their names on their forms unless they particularly wish to do so. Resources permitting, all the forms will be collated and shared with the workshop sponsor and participants.

2. Give out the forms and ask participants to complete them and return them to you before leaving the workshop.
5.3 Closing activity

What is this activity?
This activity enables participants to sum up the key points they have taken away from the workshop and provides an opportunity for them to say goodbye to one another.

Why use it?
To enable participants to reflect on the experience of taking part in this programme.

How long does it take?
10–20 minutes.

Materials you need
None.

Facilitator's notes
1. There are many different ways to close. You may want to ask participants to choose how they would like to end.

2. One simple way is to ask each participant to identify the most significant point they have learned or experienced in the workshop.

3. Confirm any agreements you have made – for example, sharing reports, further meetings or sharing of materials, before thanking all participants for their contributions.
Part 2 Participant handouts
**Handout 1 Workshop plan**

**Overall workshop objectives**

- To increase understanding of the specific needs of men who have sex with men (MSM) within the context of the HIV epidemic.
- To increase knowledge of effective and promising responses to addressing the HIV-related needs of MSM.
- To identify key priorities, related actions and appropriate partners in responding to the HIV-related needs of MSM within the overall framework of the national response.

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Handout 2 Suggested ground rules

- Valuing difference (of opinion and experience)
- Confidentiality
- Timekeeping
- Active listening
- Mobile phones and laptops switched off during the session
- Any others…?
Handout 3 Sexuality quiz

1. What does homosexuality mean?

2. What does heterosexuality mean?

3. What does bisexuality mean?

4. What does homophobia mean?

5. Are ‘MSM’ and ‘gay’ the same?

6. What are the causes of homosexuality?

7. Homosexuality can be cured — true or false?

8. What does ‘transgender’ mean?
Handout 4 Participant presentations

Please follow these instructions when preparing your presentation

1. What is the legal situation concerning men who have sex with men (MSM) in your country, region or community? Distinguish between the law and how it is implemented in terms of police practice.

2. How do people respond to MSM in your community? For example, what words do people use to describe it? Can you provide examples of situations in which MSM behaviour is accepted? If MSM behaviour is not accepted, on what grounds is this justified?

3. How is public disapproval expressed?

4. Are any groups of MSM visible in your community — and if so, how?

5. Do you know of any organisations working with MSM?
Handout 5 Country scenario 1

Your organisation is a medium-sized non-governmental organisation (NGO) based in the capital city. It has one sub-office in the second city, in the north of the country. It supports a number of small community-based organisations (CBOs) across three of the six provinces and the national network of people living with HIV (PLHIV). The three provinces in which it supports programmes are the most populated in the country, and have the highest HIV rates.

Your organisation started working in HIV eight years ago, working with the PLHIV network in the area of care and support, and adherence-support programmes. Four years ago it started a prevention programme with sex workers. Last year, it started a small pilot prevention initiative with men who have sex with men (MSM) and has developed good relationships with some MSM in the community. A recent study of 250 MSM found an HIV prevalence of 18.5% — much higher than anticipated.

A donor has put out a request for proposals to increase access of MSM to prevention and treatment services. It has US$3.8 million to award over three years. In the first year it will award US$1.3 million, of which a minimum of US$350,000 should be awarded in small grants. Your organisation wants to increase its work with MSM, and sees this as a prime opportunity to increase its services to this hidden and highly stigmatised population.

You will find some background information on the next page.

Instructions for group work

1. Read through the instructions and background information.

2. You are allowed to spend up to US$10,000 to undertake research to increase knowledge about MSM in your country. What kind of research would you propose, and what questions would you want it to answer?

3. Decide on the vision and goal of your programme, and then chose three or four, key strategies that you will use to achieve this goal.

4. For each strategy, use the Change Framework (Handout 7) to think through how you will implement the strategy and whether this will involve interventions at each level, or just at one or more. For each intervention identified, explain how this will affect the change you want to see happen. It is more important to think through each stage of the Change Framework than to present a superficial programme response.

5. You can be creative in how you present your programme, but you will be assessed on:
   • the appropriateness of your programme for this context
   • the appropriateness of the interventions to achieve the goals, and
   • how systematically you have used the Change Framework process.

6. Good luck, and have fun!
### Country Scenario 1 (continued)

#### Demography
Population: 24 million — 35% living in urban settlements and 4.6 million living in the capital city. Religion: 65% Muslim, 30% Christian, 5% other.

#### Social norms
- A very conservative and religious society. Mosque and church attendance is extremely high.
- A very vocal Muslim minority wants to introduce Shariah Law, but this is being resisted by the majority of the Muslim and Christian populations.
- Recently, two MSM were publicly beaten by locals and subsequently arrested. This caught the attention of the international press, and has resulted in a more entrenched anti-MSM position in the country.
- The MSM population is hidden, but there are known cruising areas, which have been recently targeted by police.
- Stigma towards PLHIV is extremely high.

#### HIV prevalence
- Adult (aged 15–49): 1.8%.
- Two sex-worker HIV prevalence studies have been conducted. The first, in the capital city, found a prevalence of 22% and the second, in a border town, found a prevalence of 25%.
- There was one small HIV prevalence study of 250 MSM living in and around the capital city, which found an HIV prevalence of 18.5%.

#### Current challenges for MSM
- Same-sex behaviour is illegal, and the judiciary is unsympathetic. However, a number of politicians have called for reform and decriminalisation of homosexuality. These politicians have become the target of media and religious censure.
- High levels of stigma exist across society.
- There is virtually no access to sympathetic services offering treatment for sexually transmitted infections (STI), counselling and testing, or treatment at which MSM can be open. Confidentiality is a particular issue.
- Very few people have come out openly as MSM.
- Many MSM are married.
- There is very little opportunity to meet socially, other than at cruising areas and some bars or safe houses.
- A small educated gay group does exist, but it is highly clandestine.

#### Current responses
- The national HIV strategy clearly recognises the concentrated nature of the epidemic and, led by an enlightened Minister of Health, has directed the prevention strategy to target sex workers. Last year, it included MSM.
- Members of the PLHIV network were invited to participate in the development of the latest national HIV strategy.
- The country has benefited from consistent donor funding to support its national strategy, and funding has been directed to government and civil society actors alike.
- The National AIDS Control Council has taken a collaborative approach with civil society in responding to the epidemic.
Your organisation is one of the leading national non-governmental organisations (NGOs) responding to HIV based in the capital city. It has two sub-offices: one in the second city, in the north of the country, and one on a border town in the west of the country. The neighbouring country has an adult HIV prevalence of 28%.

The organisation supports a number of small community-based organisations (CBOs) across five of the six provinces — mostly in the areas of increasing access to prevention, care and treatment services. It also supports the largest orphans and vulnerable children (OVC) programme as a sub-partner in two provinces. It has a strong relationship with the national network of people living with HIV (PLHIV), which has its headquarters in your offices.

The organisation started working in HIV 12 years ago, with a small home-based care programme. Over a six-year period it became the leading capacity-building NGO supporting care and support services. With the arrival of a new director five years ago, it began to work with the PLHIV network, and started to develop prevention programmes. However, the majority of its funding is still for care and support work — most recently, to increase access to antiretroviral therapy (ART) and for an adherence-support programme.

Your organisation started one sex-worker project in one of the border areas, but the programme collapsed when the project director left and your funding ended. Although the organisation knows some of the more open men who have sex with men (MSM) who are part of the national PLHIV network, it has never provided services to MSM.

A donor has put out a request for proposals to increase access of MSM to prevention and treatment services. It has US$3.8 million to award over three years. In the first year, it will award US$1.3, of which a minimum of US$350,000 should be awarded in small grants. During its strategic planning last year, your organisation discussed expanding its scope to work with most-at-risk populations (MARP). It sees this as a prime opportunity to increase its services to this hidden and highly stigmatised population.

You will find some background information on the next two pages.

Instructions for group work
1. Read through the instructions and background information.
2. You are allowed to spend up to US$10,000 to undertake research to increase knowledge about MSM in your country. What kind of research would you propose, and what questions would you want it to answer?
3. Decide on the vision and goal of your programme, and then chose three or four, key strategies that you will use to achieve this goal.
4. For each strategy, use the Change Framework (Handout 7) to think though how you will implement the strategy and whether this will involve interventions at each level, or just at one or more. For each intervention identified, explain how this will affect the change you want to see happen. It is more important to think through each stage of the Change Framework than to present a superficial programme response.
5. You can be creative in how you present your programme, but you will be assessed on:
   - the appropriateness of your programme for this context
   - the appropriateness of the interventions to achieve the goals, and
   - how systematically you have used the Change Framework process.
6. Good luck, and have fun!
**Handout 6 Country scenario 2 (continued)**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INLAND SOUTHERN AFRICAN COUNTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demography</td>
<td>Population: 12 million — 40% living in urban settlements and 5.2 million living in the capital city. Religion: 75% Christian, 20% Muslim, 5% other.</td>
</tr>
</tbody>
</table>
| Social norms | • Generally conservative, with high attendance at religious services.  
• Gender inequalities are very apparent, and gender-based violence is increasing.  
• There is much migration for work, and multiple-concurrent partnerships are not uncommon. Only 35% of co-habiting couples are married.  
• Alcohol use is growing. There have been some recent reports in the media of injecting drug use.  
• Rapid urbanisation is leading to the breakdown of traditional values and norms, and many of the traditional practices are being lost. |
| HIV prevalence | • Adult (aged 15–49): 16.5%.  
• Sex-worker HIV prevalence: 35% in the capital city, 55% along truck routes.  
• MSM HIV prevalence: only one study has been undertaken, with 350 participants from the capital city. It found a prevalence of 28% (12% for men aged 15–24 and 32% for men aged 35+). |
| Current challenges for MSM | • Although homosexuality is not in itself illegal, buggery laws against anal sex remain on the statute books from the colonial time.  
• Police harassment of MSM is common.  
• Homosexuality is highly stigmatised, and there is a prevalent belief that it is an imported phenomenon from the North and, more recently, from South Africa.  
• MSM have limited access to sympathetic health services.  
• MSM have been largely ignored by the National AIDS Control Programme, which does not feel that MSM are a priority.  
• There has been increased visibility of the MSM community since a popular singer came out as gay. This has created a lot of discussion of MSM issues in the media and some reports of beatings and violence towards people who are thought to be gay or MSM.  
• There is one national lesbian, gay, bisexual and transgender (LGBT) organisation with approximately 600 members. A recent survey of members identified that internet use is high, with many men meeting their sexual partners through social networking sites.  
• There is currently no peer outreach programme for MSM. |
### Handout 6 Country scenario 2 (continued)

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INLAND SOUTHERN AFRICAN COUNTRY</th>
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</table>
| Current responses at various levels | - The National AIDS Control Programme is led by a socially conservative director who was appointed by the Minister of Health and has publicly stated that homosexuality is a ‘disease’. There has been a call by donors and civil society actors to the government to sack the current director and to put in place someone who will take a more evidence-based approach to prevention.  
- The national strategic plan is guided by the ‘ABC’ approach to prevention, with a particularly strong directive towards abstinence programming for youth. Tackling stigma and discrimination is also a priority, and the National AIDS Council (NAC) has a reasonably good record of involving PLHA in planning and consultation processes. A particular priority is to increase access to HIV counselling and testing, and to treatment. The strategy mentions promotion of condoms only when referring to discordant couples and sex workers.  
- The NAC is critical of donors for what it sees as an inappropriate level of support to civil society actors in the AIDS response, and the government has questioned civil society participation in the CCM of the Global Fund.  
- There are a number of strong NGOs working in the area of HIV. Apart from your organisation, there is one international NGO that has been working with a small group of MSM in the centre of the capital. It has produced some useful reports about the MSM community.  
- The donors have been sympathetic to the needs of MSM in the country and, following the publication of the latest HIV prevalence data, have recognised the need to support MSM programming. |
### Handout 7 Change framework

<table>
<thead>
<tr>
<th>Strategic goal of the intervention:</th>
<th>Objective at individual/household level:</th>
<th>Interventions</th>
<th>How will this intervention make the change happen?</th>
<th>Challenges/risks anticipated in implementing the intervention</th>
<th>How will I mitigate and overcome these challenges?</th>
<th>How will I know that this intervention has worked?</th>
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### Strategic goal of the intervention:

### Objective at **social normative level:**

<table>
<thead>
<tr>
<th>Desired changes at social normative level</th>
<th>Interventions</th>
<th>How will this intervention make the change happen?</th>
<th>How will I know that this intervention has worked?</th>
<th>Challenges/risks anticipated in implementing the intervention</th>
<th>How will I mitigate and overcome these challenges?</th>
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### Handout 7 Change framework (continued)

<table>
<thead>
<tr>
<th>Strategic goal of the intervention:</th>
<th>Objective at services level:</th>
<th>Interventions</th>
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<tr>
<th>Desired changes at services level</th>
<th>How will I know that this intervention has worked?</th>
<th>Challenges/risk anticipated in implementing the intervention</th>
<th>How will I mitigate and overcome these challenges?</th>
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<th>How will this intervention make the change happen?</th>
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### Handout 7 Change framework (continued)

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<th>Objective at structural level:</th>
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<td>Desired changes at structural level:</td>
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<td>Interventions</td>
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<td>How will this intervention make the change happen?</td>
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<td>Challenges/risks anticipated in implementing the intervention</td>
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<td>How will I mitigate and overcome these challenges?</td>
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Handout 8 Action planning matrix

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<th>SMART objective</th>
<th>Actions</th>
<th>Person responsible</th>
<th>Immediate term (completion date)</th>
<th>Longer term (completion date)</th>
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Handout 9 Workshop evaluation form

Workshop > Responding to the HIV-related needs of men who have sex with men (MSM) in Africa

Date ........................................ Location .........................................................

1. Did the workshop meet your expectations? [ ] Yes [ ] No

2. Against each of the objectives for the workshop, please rate how you feel each of the following objectives were met, from 1 to 5, with 1 being low and 5 being high.

   a) To increase understanding of the specific needs of MSM within the context of the HIV epidemic

   b) To increase knowledge of effective and promising responses to addressing the HIV-related needs of MSM

   c) To identify key country-level priorities, related actions and appropriate partners in responding to the HIV-related needs of MSM, within the overall framework of the national response


3. Feedback on the content:
What would you have liked more information or discussion on?

Was there anything you thought was irrelevant?

4. Feedback to organisers: Please give us your thoughts about the administration, preparation and planning of the event and any other practical ways we can improve the running of similar events in the future.

5. Feedback about materials and resources: Please comment upon the resource material and any other materials, demonstrations, presentations or exercises you experienced (or would have liked) at the event.

6. Feedback to facilitators: Please give specific, supportive, challenging and constructive feedback to individual facilitators about how they managed the event, helped your learning and/or what they could do differently next time.

7. Any other comments?
Part 3 Facilitator resources
Resource 1 Glossary of sexual identity and behaviour

This glossary is a general guide to some commonly used terms. The terms and labels used are culturally specific, and even common terms may be understood differently in different contexts.

An individual may express their sexuality and sexual identity differently over the course of their lifetime. Identity is how people see and define themselves, and would like to be accepted and known by others, while ‘behaviour’ refers to what people actually do sexually.

Some terms refer to both identity and behaviour, so it is important that we are clear about what we mean. We need to recognise that just because people behave in a certain way that this does not necessarily determine their identity.

What is most important is to listen to and understand how people describe themselves and their behaviours, and start from there.

Bisexual
A term to describe someone whose emotional and sexual attraction is to people of both sexes and who identifies as such.

Gay
A term to describe a person whose primary emotional and sexual attraction is to people of the same sex, and who chooses to identify themselves as such. The term was chosen by gay people themselves in the United States as a positive affirmation of their sexuality and as a rejection of medical or negative terms. Many countries have their own equivalent terms.

Heterosexual
A man or woman whose primary emotional and sexual attraction is towards the opposite sex. In most societies, heterosexual people do not necessarily identify themselves as such, because this is assumed to be the norm.

Homosexual
The medical or ‘scientific’ term used to describe someone whose primary sexual attraction is to people of the same sex. Many men and women prefer to describe themselves as ‘gay’ or ‘lesbian’.

Intersex
A term used to describe someone born with ambiguous genitalia (and/or chromosomes).

Lesbian
A woman whose primary emotional and sexual attraction is to women and who chooses to identify herself as such.

Men who have sex with men (MSM)
A generic term to describe any man who has sex with another man irrespective of his own expressed identity. For instance, a man may describe himself as heterosexual but occasionally have sex with men.

Transgender
A term used to describe someone who dresses as, acts as, and wishes to be (or is) recognised as a member of the opposite sex — usually on a permanent or ongoing basis. This term is often used as a catch-all term for transsexual, transvestite and transgender.

Transsexual
A term used to describe a person who feels they are in the wrong biological body and wants to change — or has changed — their biological sex, either through surgery, hormone treatment or both. Following gender re-assignment surgery, a transsexual person may no longer identify as ‘transsexual’ but in terms of the gender of their re-assignment.

Transvestite
A man or woman who dresses as a member of the opposite sex occasionally. This may be for different reasons — for enjoyment or relaxation, sexual pleasure, sex work, entertainment work (dancer, singer) or for ritual purposes.
**Resource 2 Understanding men who have sex with men**

This resource identifies some common questions and answers about men who have sex with men (MSM). You will find this a useful background resource throughout the workshop.

Human sexuality is complex. Social attitudes and values concerning different aspects of sexuality, sexual behaviour and identity change over time. The most important way of learning about sex between men is by having conversations with MSM themselves. Keep an open mind, and listen to the words and terms they use to describe themselves and their peers. Your workshop will be enriched by the participation of MSM.

**Q. What is homosexuality?**

**A.** The term ‘homosexuality is not a disease. It is present, with varying degrees of visibility, in all societies. Throughout history, homosexuality has been a reflection of the diversity of human sexuality. However, cultural, religious and social responses to it homosexuality vary and change over time.

**Q. Is ‘MSM’ the same as ‘gay’?**

**A.** No. The term ‘MSM’ describes sexual activity between men, while ‘gay’ refers to an identity — how people see or describe themselves and, ideally, how they would like other people to see or describe them.

In many western countries, some (but by no means all) men who have sex with men, and women who have sex with women, describe themselves respectively as ‘gay’ or ‘lesbian’. Many women prefer to identify as gay rather than lesbian. In other countries, people use words derived from their own language or cultures to describe this kind of ‘alternative’ sexual identity.

So, while gay men are men who have sex with men, not all MSM are necessarily gay. For some MSM, having sex with other men is the kind of sex they prefer, while other men will have sex with men either because it is available, or when access to women is limited. Some men have sex with men in order to make a living. Many MSM will have sex with both men and women.

**Q. What are the causes of homosexuality?**

**A.** In every country, a proportion of people are sexually attracted to members of their own sex. This has been the case throughout history. Homosexuality is neither new nor limited to particular parts of the world, nor is it a behaviour or lifestyle imported from other cultures or countries.

For many years homosexuality was considered to be a disease, and researchers tried to understand its causes. However, in 1990 the World Health Assembly removed the term from the International Classification of Diseases. This was done in response to increasing awareness of homosexuality as a relatively common manifestation of the diversity of human sexuality. It also acknowledged the fact that categorising homosexuality as a disease was no longer justifiable on scientific grounds.

**Q. What about ‘cures’ for homosexuality?**

**A.** Gross violations of human rights have been (and continue to be), perpetrated by those professionals — for example, in the medical, psychological and religious fields — who claim to be able to ‘treat’ or ‘cure’ homosexuality, or to convert homosexuals to heterosexuality. Since homosexuality is not a disease, attempting to treat it as such is misleading and potentially harmful.

The most significant problems encountered by MSM are stigma and discrimination, which can seriously undermine their well-being. As a result of this, some MSM may ask for help to change their sexual orientation. There is no convincing evidence that this is possible. On the other hand, it is clearly possible to help people to come to terms with and accept their sexuality.

**Q. What is homophobia?**

**A.** Homophobia describes the irrational disapproval or hatred of sex between men or between women. It is expressed through stigmatisation, discrimination and, at its most extreme, violence and murder. Homophobia often reflects legal, religious and social attitudes.

Homophobia is often directed at those whom others consider to be gay or effeminate (see next question)
Resource 2 Understanding men who have sex with men (continued)

on the basis of their behaviour or dress. However, homophobia affects all gay people, MSM and those who are close to them by forcing them to hide or disguise aspects of their behaviour (for example, by marrying against their own wishes, or by being forced to have sex in secret, often in dangerous places).

Homophobia also makes it difficult to provide sexual health services, as people may not be willing to disclose information about their sexuality. Some organisations may refuse to work with MSM, or allow their staff to treat MSM badly when they do attend.

Q. What does transgender mean?
A. Transgender refers to four different aspects of sexual identity: transgender, transsexuals, transvestism and intersex. (For more details about these categories, see Resource 1: Glossary of sexual identity and behaviour.)

In most societies, assumptions are made about biological sex, gender, gendered identity and behaviour and sexual orientation. It is often assumed that:
- male genitalia = male = masculine = the person who penetrates sexually = heterosexual
- female genitalia = female = feminine (the person who is penetrated sexually = heterosexual.

There are enough examples from around the world to show that these assumptions are often mistaken. For some people, having a penis does not necessarily make them male, or masculine. Other men may dress or behave effeminately but may not be MSM — and if they are, it does not signify their preferences are in terms of penetrative sex.

In short, the fewer assumptions we make about other peoples’ sexuality, the better!
Resource 3 Men who have sex with men and HIV in Africa

This is background information to be used in conjunction with PowerPoint presentation 1.

Almost everywhere, even in generalised HIV epidemics, MSM are more affected by HIV than members of the general population. HIV epidemics among MSM also contribute to broader HIV epidemics, in that many MSM also have sex with women.

Vulnerability to HIV among MSM is both physical and social. In terms of physical risk, the highest risk sexual activity for MSM is unprotected anal sex. The partner who is penetrated is at considerably higher risk than the ‘insertive’ partner. These roles are sometimes referred to respectively as ‘active’ and ‘passive’, or ‘top’ and ‘bottom’. However, many MSM will play both roles at different times, or with different partners.

In most countries of the world, many men who have sex with men also have sex with women. An average of 20% of MSM in low-income countries report having sex with women at some time, and around 16% of MSM in these countries may also be married.

Not using condoms, or using condoms together with oil-based lubrication will increase the risk of HIV transmission. Similarly, cleaning out the rectum by passing water or other fluids through the anus — for example, by using an enema — can damage sensitive tissue and hence make infection more likely.

Oral sex is generally thought to be very low risk (but not entirely without risk) in comparison to anal sex, especially when semen is not swallowed. There is no risk of HIV transmission from kissing, masturbation (solo or mutual) and other forms of non-penetrative sex.

Some MSM use drugs recreationally. The risk of HIV arises either directly (in the case of using infected equipment to inject drugs) or indirectly (from an increased likelihood of risk-taking when high on drugs). However someone who is more prone to risk-taking may also be more likely to use drugs in the first place.

Some MSM engage in sex work and, depending upon their ability to insist on and practice safer sex, this may increase their risk of HIV.

Stigma, discrimination and criminalisation of sex between men compound risk. For example, when people are stigmatised, they can feel bad about themselves and are less likely to value and take care of themselves.

In many societies, MSM are discriminated against, including in terms of sexual health service provision. This makes them unlikely to access services, or less likely to disclose personal information when they do so.

The latest global data available on the percentage of MSM who receive HIV prevention services show that access to HIV services for men who have sex with men was approximately 12% in Africa (UNGASS 2008 country reports — see Further reading). In other words, 88% were not accessing or being reached by services. However, 71% of countries did not report on this indicator at all.

Criminalisation deters MSM from seeking services (including those relating to sexual health and safer sex) and support, for fear of being reported to the police. According to the most comprehensive ongoing survey of relevant legislation, undertaken by the International Lesbian and Gay Association (see Further reading), at least 84 countries and territories specifically outlawed sex between men in 1999. These include nine where such acts are theoretically subject to the death penalty. Three countries are known to have executed men who had sex with other men in the previous ten years.

The International Lesbian and Gay Association’s 2009 report (see Further reading) provides information, country by country, on the legal status of sex between men. Information about the situation in countries not covered by that document may be available from the other documents and organisations listed on its website.

You will find a PowerPoint slide presentation towards the end of this publication. If you intend to use this, you need to familiarise yourself with its contents and make copies for participants.
MSM + HIV + Africa

Outline

- What do we mean by MSM?
- Prevalence of HIV among MSM
- How (and why) are MSM at risk of HIV?
- Three Country Study (MSM)

Africa!

- Only continent to contain all 4 types of HIV epidemics: Low, Concentrated, Generalised and Hyper-endemic
- Diversity within and between countries
  - Culture and norms
  - Social structures
  - Behavioural expression
  - Historical development

2008 Epidemic Update

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2007</th>
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<tbody>
<tr>
<td>People living with HIV (Africa, ESA)</td>
<td>29 million (18.7 million)</td>
<td>23 million (22.9 million) (15.6 million)</td>
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<tr>
<td>New HIV infections (Africa, ESA)</td>
<td>3.2 million (1.3 million)</td>
<td>2.7 million (1.9 million) (1.3 million)</td>
</tr>
<tr>
<td>Deaths due to AIDS (Africa, ESA)</td>
<td>1.2 million (1.4 million)</td>
<td>2 million (1.5 million) (1.2 million)</td>
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</tbody>
</table>

Africa is global epi-centre
> 2/3 of PLWHAs, ¼ of deaths

ESA is home to half global PLWHA, and > ½ of global deaths and new infections

Why MSM?

- "Men who have sex with men"
  - Describes behaviour and not identity
  - Used to describe broad range of identities e.g. gay, bi-sexual, transgender (not all identify as men)
  - Men who describe themselves as heterosexual but who have sex with men
  - "Situational sex" e.g. prisons, schools, military
  - Sex workers who may define themselves as heterosexual but primarily sell sex to men

MSM are not just MSM

- People are more than how they use their genitals
- MSM is a neutral term to describe sexual behaviour but identity is also important
- Gay, transsexual and many other terms are used by MSM to describe their identity
  - Can be stigmatised but also celebrated
  - Often had/ have elevated status within communities
  - Have been hard won by generations of leaders and advocates
Part 3 > Facilitator resources

PowerPoint presentation 1

Slide 7

How/why are MSM at increased risk of HIV?

Individual level risk (Saavedra et al. 2008)

- Unprotected anal intercourse (increased risk with receptive UAI)
- High frequency of male partners (>3 sexual contacts/week)
- High number of lifetime male partners (>10)
- Untreated STI (syphilis, HSV-2)
- Drug
  - Injection drug use
  - Non-injection drugs
  - Methamphetamine (increased sexual exposure)

Slide 8

How are MSM at increased risk of HIV?

- Impact of the following on self-esteem and well-being
  - Behaviour/identity often hidden
  - Hostile socio-cultural environment
  - Denial of human rights e.g. Sex between men criminalised; no safe place to meet/socialise
  - Stigma: often leading to violence – verbal and physical
  - Discrimination: e.g. Housing; access to, and denial of, health promotional support and services
  - Health services not respondent to needs
  - Lack of targeted funding for MSM

Slide 9

What do we know about the prevalence of HIV among MSM?

- Higher among MSM than general population across the world, including Africa
- Higher among transgender population
- Until recently not considered important in Africa and therefore least studied and understood in African countries
- Prevalence among MSM influences prevalence in general population, including Africa

Slide 10

Prevalence among MSM compared to General Population?

Graph showing prevalence rates in Kenya, Senegal, and a comparison with adult prevalence.

Slide 11

Risk of HIV infection (MSM)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of countries</th>
<th>Odds Ratios</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americas</td>
<td>19</td>
<td>33.3</td>
<td>32.3 - 34.2</td>
</tr>
<tr>
<td>Asia</td>
<td>7</td>
<td>18.7</td>
<td>17.7 - 19.7</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>12</td>
<td>1.3</td>
<td>1.06 - 1.6</td>
</tr>
<tr>
<td>Africa</td>
<td>4</td>
<td>3.8</td>
<td>3.3 - 4.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of epidemic/prevalence level</th>
<th>Odds Ratios</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low prevalence countries</td>
<td>23</td>
<td>56.4</td>
</tr>
<tr>
<td>Low Prevalence</td>
<td>8</td>
<td>14.1</td>
</tr>
<tr>
<td>High Prevalence</td>
<td>7</td>
<td>9.6</td>
</tr>
<tr>
<td>Medium-High Prevalence</td>
<td>7</td>
<td>0.0</td>
</tr>
</tbody>
</table>


Slide 12

National Planning - Level of participation of the organisations representing MSM in national AIDS reviews in 38 low and middle income countries.
HIV Prevalence, Risks of HIV Infection, and Human Rights among Men Who Have Sex with Men (MSM) in Malawi, Namibia, and Botswana
Baral S, Trapence G, Motimedi F, Umar E, Scholastika L, Dausab F, Beyer C
*Plos ONE, 2009*

### 3 Country Study: HIV Prevalence
- **N = 600**
- **HIV Prevalence:**
  - Age 18 – 23: 8.3% (20/241)
  - Age 24 – 29: 20% (42/210)
  - Age 30 – 49: 35.7% (30/84)
  - Pooled prevalence = 17.4% (CI: 14.4 – 20.8)

### 3 Country Study
- Two-thirds had received MSM specific prevention information
- Oil-based lubricants – Vaseline and body/fatty creams used most often
- Condoms + water-based lubricants practised by less than 1 in 20
- One tenth reported the injection of illegal drugs

### 3 Country Study
- Very low reporting of sexual orientation to one member of immediate or extended family or health care worker
- Disclosure to family members significantly associated with blackmail and to a health care workers, being denied health care

This PowerPoint presentation can be downloaded from the Alliance website at:

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**Part 3 > Facilitator resources**

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**Resource 4 Questions for participant presentations**

Use these questions to explore the issues raised by participants in their presentations:

1. What work is going on, or has been undertaken in the past, around prevention with MSM in your country?

2. Who is carrying out this work (what types of organisations)?

3. What kinds of change have been made, and what types of approach have been used to affect this change?

   Responses might include:
   - at the individual level
   - by changing community norms or creating an enabling environment
   - by increasing access to services, or
   - through structural change — for example, by improving the legal environment or at the policy level.

   Can you provide some examples?

4. What have been the most important challenges and barriers encountered?

5. How have these been addressed?

6. Can you recommend any resources (for example, technical materials) that you have found particularly useful?
Resource 5 Key principles and strategies

This is background information to be used in conjunction with PowerPoint presentation 2.

In 2009, UNAIDS published its Action Framework on Universal Access for Men who have Sex with Men and Transgender People (see Further reading). This document argues that:

It is clear that there is an urgent need not just for more programming, but also for new and better approaches to programming. Based on local epidemiological and social realities, enhanced responses must combine efforts focused specifically on men who have sex with men and transgender people, attention to their needs in broader HIV responses, and bridge-building with broader efforts to achieve gender equality, promote human rights and protect public health.

The strategy is informed by three key guiding principles:

1. Actions must be grounded in an understanding of, and commitment to, human rights.
   A rights-based approach encourages MSM, transgender people and their female sexual partners to secure and exercise their right to the information and commodities they need to protect them from HIV and other sexually transmitted infections, together with the right to access — free from discrimination — HIV prevention, treatment, care and support.

2. Actions must be based on evidence.
   In many countries, men who have sex with men and transgender people are disproportionately at risk of HIV infection. However, rarely does the allocation of effort and resources match this epidemiological reality.

3. Comprehensive interventions — including individual-level, community-level and structural interventions — can reduce the incidence of HIV among MSM and increase access to care and support.
   These need to be of sufficient intensity, duration and scale, and address key individual, community and structural factors that create risk and vulnerability. Interventions need to be based on understanding of local realities, contexts and needs.

A comprehensive approach

According to UNAIDS, action on HIV among MSM and transgender people is an integral element component of the broader effort to achieve universal access by 2010 and the Millennium Development Goals by 2015. These international commitments are based upon the universal human rights of all people, including MSM and transgender people, to the highest attainable standards of health, non-discrimination and equality before the law, and freedom of expression and association, among others.

UNAIDS proposes that a supportive legal, policy and social environment should include:

- promotion and guarantee of human rights of men who have sex with men and transgender people, including protection from discrimination and the removal of legal barriers to access to appropriate HIV-related prevention, treatment, care and support services, such as laws that criminalise sex between males
- assessment and understanding of the numbers, characteristics and needs of men who have sex with men and transgender people regarding HIV and related issues, including risks associated with injecting drug use, sex work, prison confinement, etc.
- ensuring that men who have sex with men and transgender people are appropriately addressed in national and local AIDS plans, that sufficient funding is budgeted for work, and that this work is planned and undertaken by suitably qualified and appropriate staff
- the empowerment of men who have sex with men and transgender communities to participate equally in social and political life
- ensuring the participation of men who have sex with men and transgender people in the planning, implementation and review of HIV-related responses, including the support of non-governmental and community-based organisations, including organisations of people living with HIV
- public campaigns to address homophobia and transgender discrimination
Resource 5 Key principles and strategies (continued)

- training and sensitisation of healthcare providers to avoid discriminating against, and ensure the provision of appropriate HIV-related services for, men who have sex with men and transgender people
- access to medical and legal assistance for boys, men and transgender people who experience sexual abuse, and
- promotion of multisectoral links and coordinated policy-making, planning and programming, including health, justice (including the police), home, social welfare, similar and related ministries, at the national, regional and local levels.

Since MSM are often more affected by HIV than members of the general population, and because HIV epidemics among MSM also contribute to broader HIV epidemics, there is a clear public health rationale for promoting effective HIV prevention among men who have sex with men and transgender people.

Interventions should be evidence-informed, developed with, and protect, the rights of men who have sex with men and transgender people and should include safe access to:

- information and education about HIV and other sexually transmitted infections, and support for safer sex and safer drug use, through appropriate services (including peer-led, managed and provided services)
- condoms and water-based lubricants
- confidential, voluntary HIV counselling and testing
- detection and management of sexually transmitted infections through the provision of clinical services (by staff members trained to deal with sexually transmitted infections as they affect men who have sex with men and transgender people)
- referral systems for legal, welfare and health services, and access to appropriate services
- safer drug-use commodities and services
- appropriate antiretroviral and related treatments, where necessary, together with HIV care and support
- prevention and treatment of viral hepatitis, and
- referrals between prevention, care and treatment services; and services that address the HIV-related risks and needs of the female sexual partners of men who have sex with men and transgender people.
Principles and practice of effective responses

Presentation Overview
- Principles
- Behaviour and Social Change
- Change Framework
- Interventions

Principles
- Participation is not optional
  - Don’t assume you know what it is needed or how to do it
  - Analyse the problems and challenges together
  - Design, plan, implement, monitor and evaluate together
- Be honest – explain what you can and cannot do
- Agree expectations of participation

Principles 2
- Design and planning are essential for success
- Partnerships and collaboration
  - Identify which organisations have a common vision/ambition
  - Working together can often mean you achieve more
  - Solidarity is both a means to achieve a common goal and an end in itself

Principles 3
- Sensitise and train staff/team
  - Training team needs to include MSM as facilitators
- Design programmes that respond holistically to people’s needs
  - Link prevention, support, care and treatment services

Behaviour and social change
- Behaviour is influenced by, among other things
  - Socio-economic status – position in society
  - The context/situation – prevalent social and religious norms
  - Laws and policies – political governance
Part 3 > Facilitator resources

PowerPoint presentation 2

Slide 7

Behaviour and social change

- In order for change to happen we need to intervene at multiple levels (change theory), with multiple interventions (dose effect) and with sufficient coverage (scale)
- Interventions need to be based on a hypothesis about how the intervention will effect/produce change and, where possible, should be based on evidence

Slide 8

Behaviour and social change

- Evidence is informed by
  - Programme learning (from monitoring and evaluation, experience, operational research)
  - Good and emerging practice (tools, resources and case studies)
  - Theories of change
  - Quantitative and qualitative research

Slide 9

Change Framework

- Is useful to ensure that you have thought systematically through what you want to achieve and how you might get there
- Provides a structure to help organise thinking about why you are doing what you are doing
- Is transparent and democratic i.e. It helps everyone involved understand the rationale for what you are doing

Slide 10

Change Framework

- Recognises that change needs to happen at multiple levels
- Dynamics between internal and external drivers of behaviour are explicitly addressed
- Helps identify the most appropriate intervention at the right level to achieve the overall goal

Slide 11

Programme design

- Must be based on participatory situational/needs analysis triangulated with other sources of information/data
- Realistic and achievable given context
- Needs to identify potential unintended consequences of interventions and how they will be identified early
- Needs to take into account what donors are willing to fund
- Share risks
**Individual level**

- Increase accurate perception of risk/threat
- Increase efficacy to mitigate that risk and access commodities and services
- Decrease isolation
- Increase social capital

**Individual level: approaches**

- Community outreach
  - Peer - peer health promotion and condom distribution
  - Services at hotspots
- Informed service user
  - Health and treatment literacy
  - How to get the most out of services
- Support self-help groups and CBOs
  - Resource materials and training
  - Organisational development
  - Small grants

**Social normative level**

- Address societal factors that inhibit and limit self-determination to create an enabling environment
  - Stigma and ignorance
  - Discriminatory practices and behaviours
  - Homophobia
  - Harmful gender norms

**Social normative: approaches**

- Participatory reflection
  - PLA type activities (peer reflection)
- Community drama
  - Street theatre
  - Story telling (stories/accounts of transformation)
- Mass media
  - Radio spots and soaps and discussions/phone ins
  - TV spots, discussion forums
- Training of influentials/gatekeepers
  - Religious and civic leaders

**Service**

- Increase access of populations to commodities and services
- Ensure services are able and equipped to meet needs of populations

**Service: approaches**

- Procurement of essential commodities e.g. Water-based lubricants and condoms
  - Often based on a partnership between public providers e.g. MoH, NAC and NGOs
- Effective distribution channels
- Synergise services and institutionalise regular communication
- Training of health care and other service providers (e.g. Police)
  - Involve MSM where possible and safe
This PowerPoint presentation can be downloaded from the Alliance website at:
Published materials


Useful websites
Amnesty International www.amnesty.org

Human Rights Watch www.hrw.org


International Lesbian and Gay Association www.ilga.org

UNAIDS www.unaids.org
Murals at a school showing HIV prevention messages, Senegal.
© 2007 Neil Freeman for the Alliance
Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organisations working to support community action on AIDS in developing countries. These national partners help local community groups and other non-governmental organisations to take action on AIDS, and are supported by technical expertise, policy work and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice development, as well as policy analysis and advocacy.

Our mission is to support communities to reduce the spread of HIV and meet the challenges of AIDS. To date we have provided support to organisations from more than 40 developing countries for over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to treatment.