

# Audience Profile: Men Who Have Sex With Men

## Who They Are (and in the Context of HIV)

### **In a snapshot: living life under the radar—out of fear, shame, and necessity.**

According to UNAIDS, men who have sex with men (MSM) are those men who have sex with other men, regardless of whether they also have sex with women and regardless of whether they have a personal or social identity associated with same-sex sexual behavior (such as being gay, bisexual, or transgender). Recent research has shown that many MSM face criminalization, stigma, and abuse from all corners of society, including their own families. Many MSM trust no one, including their MSM peers, due to fear of exposure by association. Ashamed and often afraid for their safety, many turn to a life in hiding, drawing as little attention to themselves as possible to evade discrimination and violence.

### **There is no one demographic profile of MSM, but one report identified MSM as younger, primarily urban, and engaged in occasional sex work.<sup>1</sup>**

According to the National AIDS & STI Control Programme (NAS COP) in Kenya, the median age of MSM respondents was 28, most lived in urban areas, and 80 percent had a primary- or secondary-level education. Rates of reported sex work were also significant, although sex work was not necessarily performed all year, but instead seasonally or in times of financial need.<sup>1</sup>

In another study conducted in 2007 in Mombasa, nearly three-quarters of respondents reported selling sex for goods or services within the previous three months.<sup>2</sup> Hotspots for sex work included streets, home, truck stops, sex dens, escort services, and massage parlors.<sup>2</sup>

### **MSM come from a variety of economic backgrounds; wealthier MSM are able to hide their sexuality (and may sometimes be more accepted).**

The 2012 Global Men's Health and Rights (GMHR) study found that MSM with greater wealth can use their money to hide their sexuality and navigate homophobic environments—for example, by seeking private healthcare.<sup>3</sup> The study reported that middle-class MSM were afforded more acceptance into local society, in contrast with poor MSM, who had little power and were considered socially worthless. Men who were the most economically disadvantaged reported having fewer opportunities to exercise choice regarding sexual partnerships and condom use. Research conducted in 2015 in Kenya also showed that economically disadvantaged MSM had difficulty concealing their sexual practices, due to their need to solicit transactional sex partners.<sup>4</sup>

**“People will accept and respect you when you are financially stable. We have quite a number of rich and famous gays [in the community], who change their sexual partners every time. People will beat, throw insults, and stigmatize you if you are not rich or from a well-off family...A poor MSM[’s]...opinion will be perceived as worthless.”<sup>4</sup> — MSM respondent, Kenya**

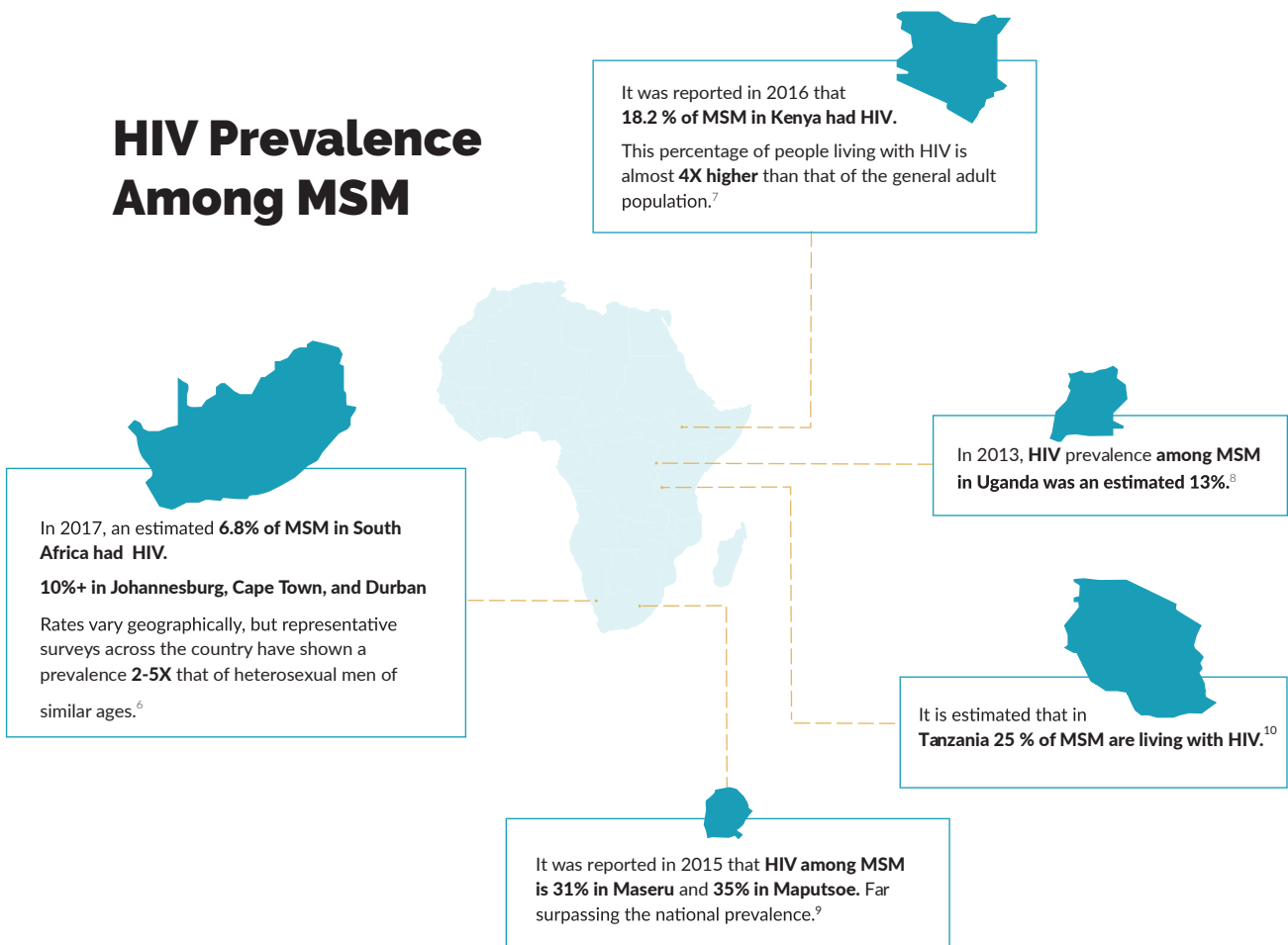
## Some MSM may live a life of mobility in order to conceal sexual behavior.

Mobility may be a key strategy to conceal MSM's sexual behavior. Because of negative perceptions, MSM often do not feel safe in any one given place—especially if they have been identified as MSM. Therefore, according to a 2017 report fielded in Kenya, many MSM are on the move within the country, as well as across borders.<sup>5</sup>

**“They operate from towns in Uganda (Jinja, Mbale, Tororo, and Iganga) and Kenya (Bungoma, Mumias, Busia, and Eldoret), where they go with clients who are long-distance truck drivers. They stay between one and seven days, then come back to Malaba, as they cannot risk being identified.”<sup>5</sup> – MSM respondent, Kenya**

## MSM face high HIV prevalence, often at rates higher than the general population.

Various studies show high rates of HIV among MSM in different sub-Saharan African countries. The 2012 GMHR study found an aggregate HIV prevalence among MSM to be more than three times higher than that of the general population across sub-Saharan Africa. In most countries with reliable data, HIV prevalence among MSM is either nearly equal to or greater than that of the general population.<sup>3</sup>



## **However, many living with HIV may be unaware of their status and underserved by health resources.**

In Zimbabwe, a 2016 UNAIDS report found that just one in seven MSM living with HIV in Zimbabwe were aware of their status.<sup>11</sup> There may also be fewer resources available to serve MSM. The 2016 AIDS progress report in Kenya found most HIV resources are directed to addressing the epidemic among heterosexual populations.<sup>7</sup>

*The following is an overview of desk research into MSM, summarizing a broad array of recent studies conducted in communities and countries across sub-Saharan Africa. While this document references broad trends and similarities within this group, there are important distinctions among MSM in different countries and contexts—even from one neighborhood to the next. When used to inform a communications campaign, this information should be a starting point for further investigation, including direct research engagement with local audiences for whom PrEP is an option.*

## Priorities, Worries, Dreams, Aspirations

*When designing a communications program, it's important to understand audience members' complex lives. This section explores MSM's priorities (not specifically related to HIV), which include their health and financial stability.*

### **MSM value financial security and economic ambitions, as well as their health.**

Quantitative market research, conducted in 2017 in Kenya by the OPTIONS Consortium, found that MSM value their health, being able to support themselves financially, and their parents.<sup>12</sup> Like many other groups surveyed by OPTIONS, MSM have financial ambitions: to save money, start their own businesses, own property or a home, and potentially move out of the country.<sup>12</sup> They worry about the high cost of living and not earning enough; 18 percent struggle with drug abuse and 14 percent with alcohol abuse.<sup>12</sup>

### **They are very concerned about contracting HIV and sexually transmitted infections (STIs).<sup>12</sup>**

The 2017 OPTIONS Kenya research found that a high number of MSM worry about becoming infected with HIV and STIs—a rate on par with that of female sex workers.

## Challenges

*Any person's risk factors for HIV acquisition are closely tied to the challenges they face. For MSM, the prejudice, stigmatization, and criminalization of homosexuality creates dire risks that often force them into lives of secrecy, which in turn increases their risk of HIV and decreases their access to prevention and treatment.*

### **MSM face discrimination, stigmatization, and violence from nearly every part of society.**

Homosexuality is widely stigmatized across sub-Saharan Africa. One survey in coastal Kenya found that same-sex behavior is widely considered “un-African.”<sup>4</sup>

**“MSM here practice secretly because it is viewed as un-African and is highly condemned... it can be traced back to times of slavery, and some think MSM practice was introduced by Arab traders.”<sup>14</sup>**

– MSM respondent, Kenya

Discrimination occurs at the hands of the criminal justice system, society, institutions, and healthcare practitioners, as well as immediately in social circles.

## **Homosexual behavior is criminalized in many countries.<sup>13</sup>**

Homophobic laws exist in many countries in sub-Saharan Africa and carry extreme punishment:

- In Kenya, sodomy carries a prison term of up to 14 years.
- In Lesotho, sodomy appears to be a common-law crime and is one of the offenses for which a person may be arrested without a warrant.
- In Zimbabwe, so-called “indecent acts” (including same-sex kissing, hugging, and holding hands) carry a one-year prison term and fines.<sup>13</sup>
- In Uganda, any form of same-sex sexual activity carries a prison term of up to 14 years. An Anti-Homosexuality Act was passed in 2014; although it was annulled later that year, it is believed to have increased harassment and prosecution of MSM.<sup>14</sup>

## **Regardless of law, MSM are frequently attacked by state officials and are victims of “mob justice.”**

MSM face threats, persecution, and physical attacks. In a 2011 report from the Kenya Human Rights Commission, MSM reported harassment, riots, beatings, lynchings, and mob justice; they also commonly received hateful messages toward them via text messages, posters, books, and printed and online publications, as well as hate speech.<sup>15</sup>

**“Pig, they should all be rounded and locked up in an island.”<sup>15</sup>** – Adult woman, Kenya

The 2011 Kenya report found that many also experience harassment at the hands of state officials.<sup>15</sup> MSM report common harassment by the police, including being held without charges or presented in court on false charges (such as having drugs falsely planted on them). MSM also report being arrested for other offenses, such as being drunk and disorderly, or for prostitution. They are also subject to extortion and blackmail at the hands of police, including demands for sexual acts in exchange for their freedom, as well as forced HIV testing and forced anal and rectal examinations.

## **MSM who are identified as such are shunned by social institutions and society.<sup>15</sup>**

MSM often experience violation and discrimination at the hands of nearly every part of society. Doctors, landlords, bankers, and lawyers have been reported to refuse service, and other public aggressions, humiliations, and ridicule are commonly reported. MSM whose sexual orientation is exposed may also be expelled from learning institutions or fired from work.

## **Organizations that support MSM's rights and health are often harassed.**

In Zimbabwe, for example, organizations that support MSM's rights to access HIV services do exist, such as Gays and Lesbians Zimbabwe (GALZ). However, many of these organizations are routinely punished and shut down, and their members are often arrested.<sup>16</sup>

## Community leaders may deny that homosexual individuals exist.

In one report fielded in Kenya, local leaders interviewed in three different sites expressed little familiarity with MSM. They said they were not sure whether this group truly existed or not, whether the group existed within their jurisdiction, or whether they existed in numbers large enough to warrant attention.<sup>5</sup>

## MSM are often stigmatized and shamed by their associates and families, and may be forced to undergo invasive and painful “correction” treatments.

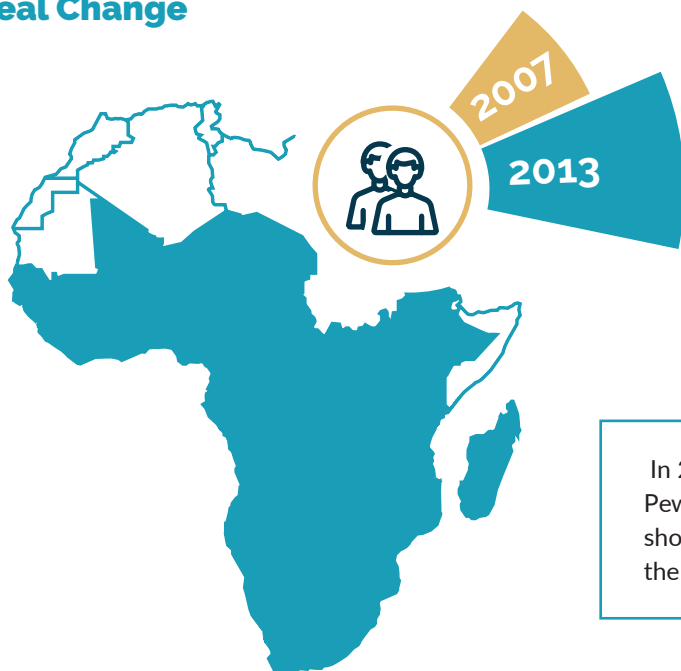
In the 2017 OPTIONS Kenya research, 68 percent of respondents said they had experienced victimization/stigmatization from people in their own circle (interestingly, a slightly higher 76 percent said they believed their peers experience stigmatization).<sup>12</sup> A 2011 report from the Kenyan Human Rights Commission also reported that many MSM are not accepted by their families and communities and that some are disowned.<sup>15</sup>

**“At 24, Amina has already been chased from his family home, forced to marry—twice—and fathered three children who ask him tough questions about sex and sexuality. He has been vilified in the national press and rejected as a disgrace by his parents.”<sup>17</sup> — Reuters, September 4, 2017**

The 2011 report from the Kenyan HRC also said that family or other relations may push MSM into abusive medical treatments. Hormonal, shock, and/or psychological therapy, as well as religious exorcism, is often used to “correct” someone of LGBTI identity, frequently without the person’s consent. Most “therapies” are forced by parents or family.<sup>5</sup>

## CASE STUDY

### Some Signs of Gradually Increasing Acceptance—but Not Enough for Real Change



In 2007, 4 percent of Kenyans told a Pew Research Survey<sup>18</sup> that society should accept homosexuality. In 2013, the number doubled.

## CASE STUDY CONT.

South Africa, which has constitutional protections from discrimination on the basis of sexual orientation, shows some similar signs of improvement:

- The same 2013 Pew survey found that 32 percent of South Africans said society should accept homosexuality.<sup>18</sup>
- In a 2016 survey of attitudes toward homosexuality in South Africa conducted by the Other Foundation, 55 percent of respondents said they would accept a gay family member, and 51 percent said gay people should have the same human rights as others.<sup>19</sup>
- Yet, 72 percent of respondents in the same 2016 survey said same-sex sexual activity was morally wrong, 18 percent had (or would consider) verbally abusing a person who is not gender conforming, and 10 percent had (or would consider) physical abuse.<sup>19</sup>

The personal experiences of MSM as reported in qualitative studies show a similarly complex portrait of moderately increasing acceptance. Acceptance seems to depend entirely on the specific dynamics of a particular family, as well as the local community. Three stories from the International HIV/AIDS Alliance website illustrate this point well:<sup>20</sup>

- Eric, 19, has not told his family he is gay and has no intention of doing so because homosexuality is “against the rules of the rural community and society at large.”
- Daniel, 20, plans to tell his family he is gay, because his cousin is already blackmailing him, demanding money and other items in return for not exposing Daniel’s sexuality.
- Hasan, 28, told his family of his sexual orientation eight years ago. His mother and brother support him and told him to “be who you are.” He attends a church that accepts him and at least three other gay men.

Broadly, acceptance is more tenuous in rural areas, although city dwellers are not necessarily “accepting.”<sup>21</sup>

**“I wouldn’t use the word ‘acceptance.’ A lot of Kenyans (in urban areas at least) don’t see the value in making a big issue of it because it doesn’t impact their life. Stigma and discrimination is far more prevalent in rural areas. Because there is less awareness, lower levels of education, and less exposure (to MSM) than there has been in urban areas.”<sup>21</sup>**

— Gay and Lesbian Coalition of Kenya, stakeholder interview in Kenya

Despite some signs of increasing acceptance, MSM still face serious stigma and discrimination.

## **Due to these serious risks and pressures, MSM often live in secrecy, experiencing persistent feelings of fear and self-loathing. Many want to remain invisible.<sup>3</sup>**

Many qualitative studies have found that MSM report poor self-worth, fear, and hiding as a result of the stigma they face:

### **Low self-worth:**

Qualitative research conducted in 2017 in Western Kenya reported on the internalization of stigma among MSM, contributing to low levels of self-worth and self-efficacy.<sup>22</sup>

**“How can I see myself as a good person when everyone and everything tells me I am a sinner?”<sup>3</sup>**

– MSM respondent, country not identified

**“I have thought that it would be better to end my life and have tried to kill myself.”<sup>3</sup>**

– MSM respondent, country not identified

### **Fear:**

The threat of discovery and exposure was a major preoccupation for many respondents in the 2012 GMHR study.

**“I worry about being found out to be MSM. My family will disown me, and some of my friends will, too. It is hard to feel safe at home knowing that anyone could report me to my landlord.”<sup>3</sup>** – MSM respondent, country not identified

**“I never know when someone might turn me in.”<sup>3</sup>** – MSM respondent, country not identified

### **Hiding:**

The 2012 GMHR study also found that MSM practice secrecy in all aspects of their lives, working to keep their sexuality invisible.

**“I cannot be myself in public, I am even afraid in private.”<sup>3</sup>** – MSM respondent, country not identified

**“When I am going out, I put on a wonderful outfit, but I must cover it up. If not, I will become a target for ridicule or violence.”<sup>3</sup>** – MSM respondent, country not identified

**“Because of my sexual orientation, I have always tried to attract as little attention as possible, afraid that people will call me names or, even worse, attack me. This is a characteristic I share with many other LGBTs in my country, Kenya. Many of us belong to a hidden society that tries to remain as invisible as possible in order to avoid the confrontation of daily abuse, stigma, and discrimination.”<sup>23</sup>** – MSM respondent, Kenya

The U.S. Department of State’s Country Reports on Human Rights Practices for 2016 stated that MSM may not report incidents of violence due to fear of stigma.<sup>24</sup>

## Most MSM hide their sexuality and frequently marry women in order to avoid suspicion.<sup>25</sup>

In interviews as part of a 2008 study in South Africa, many MSM said they maintain concurrent relationships with men and women.<sup>26</sup> This finding is supported by participants in a series of qualitative interviews across Southern Africa in 2015, who noted that many MSM marry women to hide their sexuality or because of familial pressure.<sup>27</sup>

One qualitative research study in Uganda revealed that men employ various strategies to hide their relations with other men. Some said that they have initiated relationships with women as a disguise, masquerading as straight men. Others mentioned that they changed residence frequently so that people who might harass them would not be able to find them.<sup>28</sup>

**“I have a wife. I don’t love her because I married her to please my mother. I love my boyfriend most.”<sup>15</sup> — MSM respondent, Kenya**

A 2017 study in Lesotho found that only 32.5 percent of MSM had disclosed the fact that they engaged in sex with other men to any member of their immediate or extended family.<sup>25</sup>

## Secrecy makes it difficult for MSM to maintain healthy, supportive relationships.<sup>27</sup>

The inability to trust and share one’s sexuality can have major consequences on emotional health and personal relationships. In a 2015 qualitative study conducted across Southern Africa, married MSM described how secret relationships on the side can cause instability and conflicts with a neglected wife.<sup>27</sup>

Participants in the 2012 GMHR study similarly described how the need for secrecy—driven by criminalization, police harassment, and cultural norms—undermines their ability to sustain or develop close personal relationships.<sup>3</sup>

**“The relationship does not last because at the end of the day, the relationship is not going anywhere. There is no point in the relationship because it will not end in marriage. I think that is why the relations are short; MSM in Lesotho cannot get married.”<sup>27</sup> — MSM respondent, Lesotho**

**“One of the challenges within the gay community is that there is a culture of unfaithfulness amongst friends.”<sup>27</sup>— MSM respondent, Lesotho**

**“When I see someone I know in public, I cannot greet him if he looks like he might be perceived to be MSM. By association, I will be at risk.”<sup>3</sup> – MSM respondent, country not identified**

## Fear and the need for secrecy mean that some MSM are not even willing to trust other MSM.<sup>4</sup>

Many participants in a 2015 study in coastal Kenya said they view their peers with suspicion and expressed the belief that other homosexual men cannot be trusted.

**“No, I don’t like them. Aren’t you aware of MSM? You know the MSM exhibit some funny characteristics when in a group. They like talking much and backbiting one another. They hate each other...MSM don’t have a spirit of togetherness.”<sup>4</sup> — MSM respondent, Kenya**



**“I don’t associate with MSM for personal safety...it won’t be a coincidence if people see you walking and talking with other MSM. I would come alone if we are called for a meeting. I wouldn’t use the same van with them. I strive to maintain my dignity despite my being an MSM.”<sup>4</sup> — MSM respondent, Kenya**

## **Suffering silently and alone has negative consequences for MSM, including depression, low self-worth, and other mental health issues that can increase risky behaviors.**

Being forced to hide their sexuality from family, friends, coworkers, and broader society can lead MSM to internalize shame and lower their self-worth, which can manifest in depression and anxiety. Overall, poor mental health creates challenges for MSM that may call for more holistic care.<sup>3</sup>

A 2015 research study found that Basotho MSM were almost three times more likely to be depressed if they had experienced acts of stigma or rejection.<sup>27</sup> A 2017 study of MSM in Uganda found that 40 percent of participants experienced homophobic abuse and 44.5 percent of MSM experienced suicidal thoughts.<sup>29</sup> These serious issues may also increase HIV risk, as depression has been shown to decrease situational self-efficacy and increase sexual risky behaviors.<sup>27</sup>

## **Relationship to Health & Healthcare**

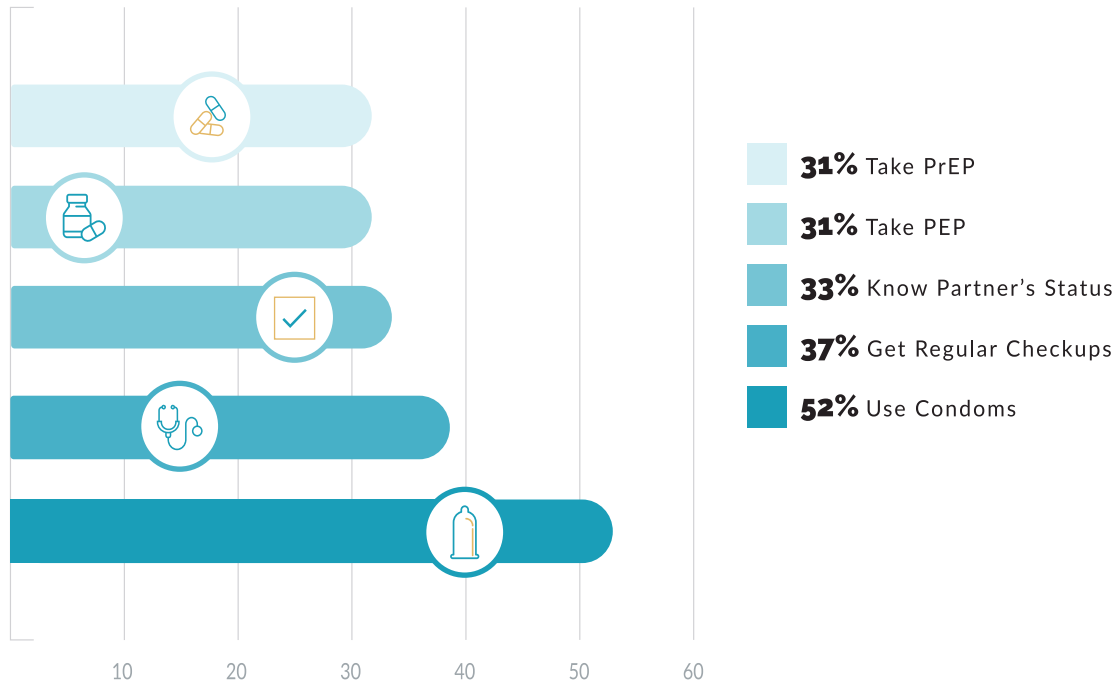
*This section examines how MSM think about their health broadly, especially with respect to preventive health practices. It also considers their access to and interactions with formal healthcare. MSM are very concerned about their health and engaged in preventive practices. However, stigma and discrimination create serious barriers to accessing the care MSM know they need.*

### **MSM are likely to be concerned about their health—especially HIV and STIs—and engaged in preventive health practices.<sup>12</sup>**

According to the 2017 OPTIONS Kenya research, 58 percent of MSM surveyed are very concerned about their health. They are very concerned about contracting HIV and STIs and believe their peers are afraid of the same things.<sup>12</sup>

The study found that MSM’s behaviors generally follow the trend of their fears. They rely on condoms and stay faithful to one partner. Safe sex sits squarely under the term “prevention” for this audience. More than any other high-risk group, MSM are likely to practice safe sex. MSM in Kenya reported the following rates of preventive practices:<sup>12</sup>

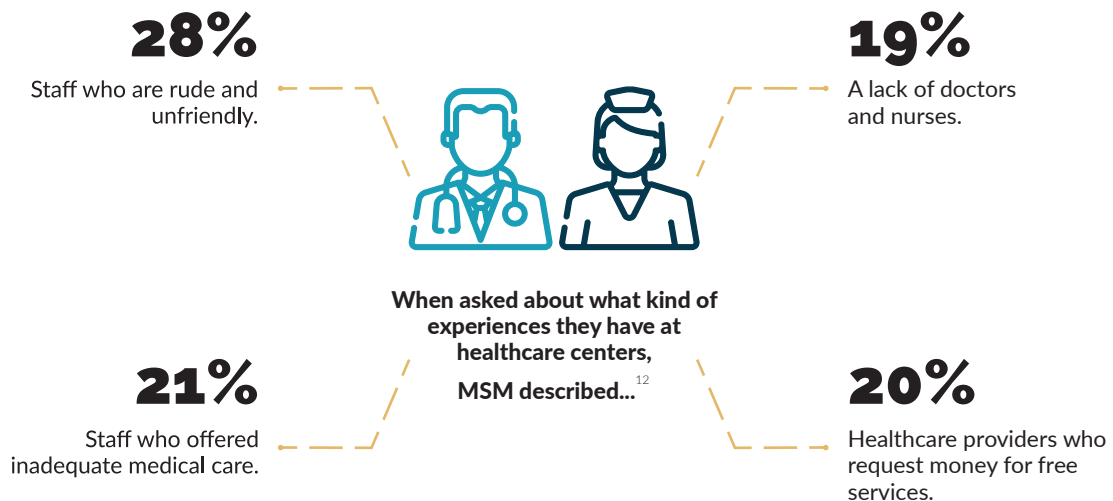
## MSM Preventative Practices In Kenya<sup>12</sup>



### While MSM prioritize health care, negative perceptions of healthcare inhibit their access to it.

The 2017 OPTIONS research found that MSM visit nongovernmental organization hospitals a majority of the time (56 percent). Most MSM (88 percent) seek healthcare alone, although 18 percent will go with friends.<sup>12</sup>

Unlike other high-risk groups studied, almost a third of MSM also visit drop-in centers. This is likely due to their negative attitudes about government healthcare, which are more prevalent among MSM than among other groups studied by OPTIONS.<sup>12</sup>



In the OPTIONS research, 63 percent of respondents cited using prayer for healing and protection against illness, and close to one in three said they would take herbal or traditional medicine for healing and remaining healthy or to prevent certain diseases. Twenty-three percent said they did not engage in any religious or cultural practices to remain healthy or prevent diseases.<sup>12</sup>

## **MSM experience discrimination from healthcare workers, who often lack sensitivity or fail to protect confidentiality.**

A 2013 cross-sectional analysis of both qualitative and quantitative studies concluded that MSM in Nairobi experience hostility, judgmental attitudes toward same-sex desire, and other negative experiences with healthcare workers.<sup>30</sup> In South Africa, a 2008 study similarly found that all of the respondents had witnessed or experienced homophobia from healthcare workers.<sup>26</sup>

As an example of this kind of negative experience, a 2011 report from Nairobi described a young man who went to a hospital emergency room seeking post-exposure prophylaxis (PEP). He was told to write his problem on an envelope and put it in a box, which a triage nurse uses to prioritize cases. After waiting 56 minutes, the man was brought to see the nurse, who scolded him in front of other staff members: “You’re a boy, how do you go on engaging in anal sex?” The patient left without the much-needed treatment.<sup>3</sup>

**“The way I am treated makes me feel worse when I leave than when I came in.”<sup>3</sup>**

– MSM respondent, country not identified

**“[A doctor] spent more time trying to find out if I was MSM than he did on the examination. I knew if I told him, it would not be good for me.”<sup>3</sup>** – MSM respondent, country not identified

A 2017 Human Sciences Research Council (HSRC) report from South Africa suggests that these negative experiences are caused by inadequate sensitization training, as well as healthcare providers’ ignorance about creating same-sex-friendly spaces or providing services appropriately.<sup>31</sup> Such attitudes were reflected in a 2013 interview with a healthcare worker, conducted as part of a qualitative study on sensitivity trainings:

**“We perceive them negatively and feel that they don’t deserve our services. Some health workers don’t like to examine them. They claim that such infections are self-inflicted.”<sup>32</sup>** – Healthcare worker, Kenya

## **MSM may also fear being exposed or stared at in healthcare situations.**

According to the 2014 UNAIDS Gap Report, some studies have found that MSM are worried that they will be stared at when seeking care. In one qualitative study, nearly two-thirds of respondents in Kisumu, Kenya, reported feeling some discomfort when seeking health services at a public hospital directly related to the fear that people would stare at them.<sup>33</sup> Similar findings have been reported in South Africa and Malawi.<sup>34</sup>

## **Uncomfortable and worried about confidentiality and discrimination, many MSM are reluctant to seek health care.**

As a result of discrimination and fear, many MSM avoid seeking healthcare,<sup>34</sup> as described in the 2014 UNAIDS Gap Report. The fear of being identified as homosexual deters many men from accessing HIV services and leads them to avoid healthcare checkups and treatment for anal infections and other potentially indicative symptoms.<sup>34</sup> Similarly, participants in the 2012 GMHR survey said they prefer to protect their sense of self and emotional well-being by avoiding healthcare settings rather than face persistent verbal abuse by healthcare providers.<sup>3</sup> A 2008 report in South Africa also found that providers’ verbal abuse targeting MSM barred MSM from seeking care.<sup>26</sup>

In a 2017 study conducted by FHI360, MSM in Eastern Kenya were shown to avoid stigma by traveling long distances (often at great cost) to seek care where they are not known.<sup>5</sup> However, many MSM are likely to avoid this hassle and cost by avoiding care. As UNAIDS described in 2014, this avoidance can lead to risky choices, such as seeking out unqualified care and self-medicating.<sup>34</sup>

## **MSM are also often unwilling to reveal their sexuality to healthcare workers as a defense against stigma.**

In addition to avoiding care, the 2014 UNAIDS report explained that MSM will often conceal their sexuality from healthcare workers.<sup>34</sup> This is problematic, as failure to do so is associated with misdiagnosis, delayed diagnosis, and delayed treatment, which in turn can lead to a poor health prognosis and greater risk of HIV transmission.

- According to the 2012 GMHR study, few MSM surveyed in Malawi, Namibia, and Botswana had ever disclosed same-sex practices to a health professional. Nearly 20 percent reported being afraid to seek healthcare. The study indicated that fear of seeking health services was strongly associated with experiences of discrimination.<sup>3</sup>
- In Zimbabwe, the 2017 HSRC study found that MSM felt the need to “act straight” when seeking healthcare services, citing experiences with homophobic stigma and discrimination at public healthcare services.<sup>35</sup>

In Lesotho in 2017, researchers spoke with MSM who were connected to the only LGBT group in the country. Even among these relatively more-connected MSM, only 24.4 percent had disclosed their same-sex sexual practices to even a single health worker.<sup>25</sup> Rates of disclosure among MSM without such connections are expected to be lower.

## **Greater comfort with healthcare workers would decrease HIV risk.**

### **CASE STUDY**

#### **Not just stigma: Why Healthcare Workers Struggle to Serve MSM in Kenya**

The poor experiences with healthcare workers reported by MSM across sub-Saharan Africa are not entirely driven by homophobia. Individual and systemic barriers prevent healthcare workers from being prepared and sensitive in their work with this group.

For example, at the individual level, healthcare workers receive little to no professional training on working with MSM. The present curriculum for HIV testing counselors does not address the possibility that male clients may be having sex with other men. This lack of knowledge, skills, and treatment guidelines leaves health professionals feeling inadequately prepared.<sup>36</sup>

At the broader level, the invisibility of MSM is also built into the system of many facilities. For example, healthcare workers in one study explained that assessment forms do not collect information about same-sex behavior or anal sex practices, reinforcing the taboo surrounding the issues, creating discomfort, and encouraging silence. Similarly, workers described how the physical structures of health facilities prevent them from providing private and confidential sexual health consultations.<sup>32</sup>

These structural barriers may be found across sub-Saharan Africa. Participants in a study conducted in Southern Africa cited the experience of healthcare facilities as “straight spaces,” where attitudes consistent with the assumption of heterosexuality as the norm were a barrier that inhibited MSM without a word being spoken. This assumption made them feel the need to “act straight” before they could access services or even have the courage to enter healthcare facilities.<sup>31</sup>

In its 2012 survey, GMHR found that MSM's reluctance to reveal their sexual lives to healthcare workers was related to misdiagnosis, delayed diagnosis, and delayed treatment.<sup>3</sup> GMHR also found that, compared to MSM who reported the minimum level of comfort with service providers, MSM who reported the maximum level of comfort 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 educational materials

## Relationship to and Engagement in High-Risk Activities

*In this section, we specifically look at the behaviors and social norms that commonly put MSM most at risk of HIV acquisition. For MSM, activities that increase HIV risk are connected to the stress and mental health issues associated with stigma and abuse. These include alcohol and drug abuse, as well as difficulty in establishing strong and trusting relationships.*

### **Risky behaviors are common (to varying degrees) among MSM.**

In 2015 research conducted in coastal Kenya, a number of behavioral HIV risk factors among MSM were identified, including:<sup>4</sup>

- Condomless anal sex
- Transactional sex
- Alcohol use
- Low HIV knowledge
- Low access to prevention programs and clinical services

Another study from 2017, among MSM in Kampala, reported the prevalence of the following common behaviors:<sup>4</sup>

- Having multiple casual partners (64 percent)
- Having multiple steady partners (54 percent)
- Selling sex (38 percent)
- Regularly engaging in unprotected anal sex (36 percent)
- Injecting drugs (32 percent)

In 2015, researchers in Kenya found a high prevalence of multiple sexual partners among single MSM: All single MSM (about 50 percent of the study participants) reported having casual sexual partners. Fifty-five percent of those single MSM reported having three to five sexual partners in the last year.<sup>37</sup> A 2015 paper published in the Journal of the International AIDS Society suggested that young MSM may be more likely to engage in these overlapping risky behaviors, such as injecting drugs and selling sex, making them even more vulnerable to HIV.<sup>38</sup>

A common denominator for these risky behaviors in some contexts may be the emotional and mental stress of living in homophobic societies.

## **Many risk-taking behaviors are associated with the mental and emotional hardships that MSM face due to stigma and abuse.<sup>39</sup>**

The injury to social and interpersonal relationships that many MSM suffer leads to poor self-worth, depression, and anxiety, and undermines health-seeking behaviors, according to the 2012 GMHR survey.<sup>3</sup> Previous research published in 2012 by the SHARP program has indicated that conflict about sexual identity—such as internalized homophobia or social stigma—as well as ambivalence toward sexual behavior are associated with engaging in risk-taking behavior.<sup>40</sup>

Both men and women may be more susceptible to decreased condom and contraceptive use, as well as increased alcohol or substance use, in sexual situations when they are conflicted or ambivalent about their sexual identity. For MSM specifically, it has also been found that experiencing homophobic abuse is associated with a higher likelihood of being infected with HIV.<sup>40</sup>

The stigma around homosexuality also increases risk by driving social isolation. A vicious cycle may occur when one's same-sex behaviors and attraction become exposed, leading to greater ostracism and discrimination, which in turn leads to increased social vulnerability to HIV-risk behaviors, such as soliciting transactional sex partners. This cycle is described in Miriam Midoun's 2012 report on coastal Kenya.<sup>4</sup>

## **MSM also have higher-than-average rates of alcohol and drug abuse, which increase high-risk behavior.<sup>41</sup>**

Alcohol, drug, and tobacco use all occur at significantly higher rates among MSM than in the general population; this is one of the most widely acknowledged MSM health concerns. The 2017 HSRC study in Southern Africa suggested that MSM may use substances to lessen inhibitions when exploring sexuality and to reduce pain during intercourse.<sup>31</sup>

Poor mental health caused by stress may be a key contributor to substance abuse. Alcohol and drug abuse tend to increase high-risk sexual behavior, such as not using a condom.<sup>42</sup> In the 2017 OPTIONS research, 27 percent of MSM reported receiving sexual pressure while under the influence of alcohol. A further 10 percent reported receiving sexual pressure while under the influence of drugs. Both of these rates were higher than those for every other audience group. When asked about how they respond to the sexual pressure, roughly one in five reported "giving in," with the explanation that "there is nothing [they] can do."<sup>12</sup>

## **MSM may have difficulty establishing strong, trusting sexual relationships. A lack of disclosure and a lack of intimacy may increase risky behavior.<sup>4</sup>**

A 2015 study in coastal Kenya found that difficulties in establishing trusted networks often produced social interactions that revolved around sex rather than emotional kinship.<sup>4</sup> Participants frequently cited having concurrent, casual sexual relationships in lieu of companionate relationships. Love, companionship, and communication were viewed as the domain of heterosexual relationships, while relationships between men were more commonly seen as primarily based on sex and/or the exchange of goods.<sup>4</sup>

## **MSM have a higher-than-average awareness of their own HIV risk; however, those with HIV are likely to be unaware of their status.**

The 2017 OPTIONS research in Kenya showed that MSM generally have a fairly accurate perception of their HIV risk.<sup>12</sup> Roughly half (49 percent) of MSM interviewed reported feeling personally at risk of contracting HIV.<sup>12</sup> When asked about the reasons for this risk, those most commonly cited were:

- Inconsistent condom use (53 percent)
- Not knowing a partner's status (40 percent)
- Having sex with someone other than a regular partner (32 percent)<sup>12</sup>

Despite relatively accurate perceptions of personal risk, MSM are very likely to be unaware of their HIV status. A 2016 UNAIDS report found that only 14.1 percent of MSM who are living with HIV are aware of their status.<sup>11</sup>

## While MSM have stronger-than-average condom use overall, rates of condom use vary widely in specific countries and locations, and use is still inconsistent overall.

MSM in the 2017 OPTIONS research identified condoms as a key preventive measure. Nevertheless, there is still a need to increase condom use and consistency with this audience. A few studies show examples of how condom use may vary across different countries:

- **Kenya:** In the 2016 AIDS Progress Report, 80.4 percent of MSM reported the use of a condom the last time they had anal sex with a male partner.<sup>7</sup>
- **Zimbabwe:** According to the 2014 baseline needs assessment report of the SHARP program, 51 percent of MSM reported condom use every time they have sex.<sup>40</sup>
- **Tanzania:** In a 2014 study published in the journal AIDS and Behavior, only 28.8 percent of MSM in Tanzania reported using condoms every time they have sex.<sup>43</sup> Similarly, in 2014 the Tanzania Ministry of Health published a report showing that 45 percent of MSM reported using a condom during their last sexual contact.<sup>44</sup>

Variation in condom use is not only related to country. MSM have different identities, motivations, and types of relationships, all of which may have an impact on their use of condoms. For example, the 2014 study in Tanzania mentioned above found that MSM in Dar es Salaam who engaged in sex work were more likely to use condoms and have higher numbers of both male and female partners, while men who reported that they sought love/affection were less likely to request or use condoms.<sup>43</sup>

A 2015 study from Uganda, published in the Public Library of Science journal, listed the following common barriers to condom use: access challenges, lack of knowledge and misinformation about condom use, partner- and relationship-related issues, financial incentives and socioeconomic vulnerability, and alcohol consumption.<sup>45</sup>

**“There are some that just don’t like condoms and just don’t use them, but for others, condoms and lubricants just aren’t available, so they feel that there are few support mechanisms [to help keep them HIV-free].”<sup>21</sup> — Stakeholder interview with AVAC respondent, United States**

## Misconceptions prevent MSM from accurately assessing their HIV risk and contribute to inconsistent rates of condom use.

A 2009 study published in the journal Culture, Health, & Sexuality described how some men believe that anal sex is “safer” than vaginal sex and were therefore less willing to wear a condom for anal sex.<sup>33</sup> Others believe that only those engaging in insertive anal sex (known as “tops”) are at risk. Another myth is that a man who does not have sex with a woman is still a virgin, and thereby not at risk of contracting HIV. This myth has been cited in multiple studies showing that some MSM believe they cannot be infected.

**“Because I only have sex with men...you see? I don’t have sex with women...for me, I know that only a woman could be carrying the virus and infect a man.”<sup>25</sup> — MSM respondent, Kenya**

# Relationship to Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment

*This section examines MSM's access to and habits with important preventive practices specifically related to HIV. A 2012 GMHR survey found three broad categories of factors that influence MSM's access to HIV services: 1) relationship with healthcare providers (whether MSM experience stigma or comfort), 2) experience of homophobia and homophobic violence in the wider community, and 3) engagement with the local community of MSM.*

## **Fear and stigma experienced in relation to the healthcare system prevent MSM from HIV testing and seeking care.**

As with MSM's avoidance of healthcare in general, stigma, homophobic violence, and fear often lead MSM to avoid HIV testing and care.<sup>29</sup>

For example, a cross-sectional study about Kenya published in 2017 in the International Journal of STD & AIDS found that experiencing social stigma was consistently associated with lower odds of HIV testing in the past 12 months, over and above all other variables assessed in the survey.<sup>22</sup> The study also found that discrimination by healthcare workers hindered many MSM from seeking HIV testing services.<sup>3</sup>

In the 2012 GMHR study, homophobic violence and past experiences of stigma by providers were also significantly associated with lower access to HIV testing among MSM living in sub-Saharan Africa:<sup>3</sup>

- Those who reported the lowest level of violence were five times more likely to report easy access to HIV testing than those who reported the highest level of violence.
- Those who reported the lowest levels of perceived homophobia were 12.5 times more likely to report easy access to HIV testing than those who reported the highest levels of perceived homophobia.<sup>3</sup>

The 2017 HSRC study in Southern Africa interviewed 27 MSM couples and similarly found that negative experiences at public health facilities—and the fear of repeating them—inhibited MSM from exercising their right to access available services intended to reduce the transmission of HIV.<sup>31</sup>

## **Fear of the stigma of HIV may also compound reluctance to test.**

MSM participants in the 2012 GMHR survey indicated that they feared the “double stigma” of testing positive for HIV. They worried about others finding out about both their sexual identity and their HIV status.<sup>3</sup> The 2017 OPTIONS research in Kenya found that this fear may be based on experience, as about one in three MSM had experienced verbal abuse because of “being HIV positive,” regardless of their status.<sup>12</sup> Participants in the GMHR survey also explained that HIV stigma originated from both the general community and the MSM community:

**“There are occasions when gay people do not collect their medication at the health centers because of fear that their status will become a subject of gossip in the gay community.”<sup>3</sup>**

— MSM respondent, country not identified



## MSM consider condoms the main way to prevent HIV; they use other methods but do not associate PEP and PrEP with “safe sex.”<sup>12</sup>

The 2017 OPTIONS research showed that MSM in Kenya consider condoms the main way to prevent HIV, but they also consider other preventive measures more so than other target audiences for PrEP. Reported rates of known ways to prevent HIV transmission include:

- Going for regular HIV tests (52 percent)
- Taking PrEP (50 percent)
- Taking PEP (37 percent)
- Being open about their HIV status (35 percent)<sup>12</sup>

When asked what “safe sex” means, 96 percent of MSM interviewed cited using male condoms and 54 percent cited testing with their partners prior to engaging in sexual intercourse. Note, only 1 percent cited taking PEP and PrEP as practicing safe sex.<sup>12</sup>

### Condoms Are the Primary Safe Sex Method among MSM<sup>12</sup>



### But condom accessibility across sub-Saharan Africa may still not be reliable.

In the 2012 GMHR survey, a low proportion of MSM in sub-Saharan Africa reported having easy access to the following safe sex and preventive measures:<sup>3</sup>

- Free or low-cost condoms (47 percent)
- Condom-compatible lubricants (19 percent)
- HIV testing (48 percent)
- HIV treatment (27 percent)
- HIV educational materials targeted at MSM (14 percent)

## CASE STUDY

### Increasing Access in Kenya

Preventive and protective measures are increasing in Kenya, according to the 2016 Kenya AIDS Progress Report.<sup>7</sup> That report showed the percentage of men who report using a condom in their last instance of anal sex with a male partner rising in recent years:

- 2011: 54.9 percent
- 2013: 68.8 percent
- 2015: 80.4 percent

Similarly, the report showed that the percentage of MSM who have received an HIV test in the past 12 months and know their results has increased:

- 2011: 35.5 percent
- 2013: 74 percent
- 2015: 76.8 percent

Backing up these findings, the 2017 Kenya OPTIONS research found that an overwhelming majority of MSM surveyed were aware of their HIV status and get tested regularly. Of the MSM interviewed, 97 percent reported knowing their HIV status, and 79 percent reported getting tested for HIV in the last one to three months. Further, 74 percent reported testing every two to three months.<sup>12</sup>

### However, HIV Risk and Prevention Education Can Still be Helpful for This Group.<sup>45</sup>

In a qualitative and quantitative study in Kisumu, Kenya, several MSM interviewed cited “lack of knowledge” as a risk factor. In the survey portion of the study, about 68 percent of respondents were categorized as having high knowledge of HIV risk factors, but about 17 percent demonstrated low knowledge (i.e., they incorrectly reported that lack of condom use in anal sex was not a risk factor).

**“Some MSM don’t know the importance of using lubricants, the use of condoms.”<sup>45</sup>**

– MSM respondent, Kenya

**“The greatest need [is] the information concerning the use of lubricants, because most of the MSM do not know...how to use the lubricant.”<sup>45</sup>** – MSM respondent, Kenya

## Relationship to PrEP

When thinking about how best to influence an audience's behavior and encourage PrEP uptake, it is important to consider five factors: 1) awareness, 2) understanding, 3) benefits, 4) interest, and 5) barriers. This section looks at how MSM currently understand and consider PrEP across these five dimensions:

- Awareness is high.
- Understanding is also high.
- Benefits for MSM (perceived) include a sense of liberation and an added layer of security.
- Interest is high, as many are already familiar with PrEP and PrEP users.
- Barriers to uptake include fear of side effects and the stigma of HIV.

### **Research shows awareness is higher among MSM than other target audience groups.<sup>12</sup>**

In the 2017 OPTIONS research in Kenya, 81 percent of MSM interviewed reported awareness of PrEP. The most common methods of becoming aware of PrEP were:

- LVCT Health (72 percent)
- Word of mouth (32 percent)
- Medical professionals (22 percent)
- Seminars (15 percent)

Not only are they aware of PrEP, but they are familiar with it, too; 84 percent of MSM interviewed cited that they know someone in their close circles who uses PrEP.

### **However, awareness should be confirmed in each context with more research.**

Awareness will vary by community and country and should be confirmed at the local level. For example, the 2017 HSRC study in Southern Africa found that only 33 percent of MSM interviewed had heard of PrEP.<sup>31</sup>

### **Awareness also seems to translate into understanding, as MSM express confidence in PrEP and its effectiveness.<sup>12</sup>**

After reading through a PrEP information sheet, 92 percent of MSM interviewed reported being “sure that it would work” in preventing HIV transmission. And unlike other audiences, MSM feel less of the need for education about PrEP and how it works. Among MSM who report they do not feel at risk of contracting HIV, 42 percent cite “taking PrEP” as their reason.

### **MSM consider the benefits of PrEP to be security and a “sense of liberation;” there is a real opportunity to normalize the use of PrEP because the benefits are well understood.**

A number of studies suggest that MSM see powerful benefits to PrEP and are willing to consider it, according to a report from a 2016 meeting on “PrEP for MSM in Africa,” which suggested there is an opportunity for communications to normalize the use and encourage uptake. The benefits of PrEP include:

### **Additional security<sup>21</sup>**

**“I tell them, ‘Security starts with you. PrEP starts with you. You are securing the future. You are securing your health.’”** – PrEP ambassador and MSM peer educator, stakeholder interview, Kenya

### **A focus on improving health overall<sup>46</sup>**

**“Drug made me responsible, seeing doctor regularly, getting screenings...more well-informed than I was four months ago when I went on it.”<sup>46</sup>** – MSM respondent, South Africa

### **A sense of liberation<sup>46</sup>**

**“Before starting PrEP, I was the poster child for using condoms and safer sex. But I wasn’t enjoying sex, and I wanted more freedom.”<sup>46</sup>** – MSM respondent, South Africa

**“When I first had sex with PrEP, I felt liberated.”<sup>46</sup>** – MSM respondent, South Africa

## **Of all the audience groups, MSM have a relatively well-established relationship with PrEP, and there is definite interest in using it.<sup>12</sup>**

The Kenya quantitative research found that 68 percent “definitely would” use it and 20 percent “probably would” use it. Six percent cited that they are already taking PrEP, more than any other audience group interviewed.

The main reason to use PrEP cited by study participants was a lowered risk of acquiring HIV.

## **The barriers to overcome are side effects and stigma.**

Side effects are the main concern about PrEP use. In the 2017 OPTIONS Kenya research, most MSM (56 percent—more than other audience groups surveyed in the same research) found the side effects of PrEP concerning. Other worries that stand out among MSM are that PrEP is rumored to cause cancer (cited by 27 percent) and kidney failure (cited by 18 percent).<sup>12</sup> Concerns were also cited (by 28 percent) about the safety of taking PrEP in conjunction with other prescribed medication.

Stigma is also a major roadblock. As with many HIV interventions, being assumed to have HIV is a major barrier to uptake, overshadowing for many that PrEP lowers HIV transmission.<sup>12</sup> The second-most common barrier relates to others assuming they are promiscuous; as a result, many consider it necessary to keep their PrEP use a secret.

In this context, information, education, and communication materials can play an important role in helping audiences overcome individual and social beliefs about PrEP that are acting as barriers to uptake.

## **Adherence becomes tricky when alcohol gets involved and because taking daily medication may be an uncommon habit.<sup>12</sup>**

When asked for reasons that might cause someone to not take PrEP every day, 49 percent of MSM interviewed cited “being too drunk to remember” and 48 percent cited being “not used to taking medication daily.”

## How to Reach and Connect with MSM: Best Channels to Connect

The following details primarily reflect the findings of the 2017 OPTIONS research in Kenya; except where otherwise noted, these insights are specific to MSM in Kenya. Like all the information in this document, the insights from research in Kenya are only a starting point for further investigation focused on a specific audience and context.

### **MSM's main interests include:<sup>12</sup>**

Listening to music, watching TV, watching movies, socializing with friends, being on social media, traveling locally, and taking photos.

### **Mass media may be a difficult channel to use due to homophobia, but channels are available:**

At a country level, radio dominates. Radio and TV are the best ways to reach MSM on mass media (68 percent own a TV and 81 percent own a radio).<sup>12</sup>

In some hostile or political environments, typical mass media approaches may not be viable, despite some improvements. Some channels may offer opportunities: For example, in Kenya, the organization Men Against AIDS Youth Group is supportive of MSM, and hosts a weekly radio show on Radio Osienala exploring issues related to MSM. The 50-minute show is a lively, educational, and entertaining program delivered in Dholuo, the main language of western Kenya.

### **Channels that MSM already engage with and turn to daily for information on healthy sexual practices and HIV prevention:<sup>12</sup>**

- Social media
- Peer educators
- Newspapers
- Hospitals/health centers
- Radio stations and TV
- Doctors

Many MSM have mobile access; of those interviewed in Kenya, 90 percent had access to a cellphone. Of these, 96 percent had their own cellphone, and 77 percent has access to a smartphone.<sup>12</sup>

### **Some MSM currently use word of mouth to find welcoming clinics.**

In interviews conducted as part of a 2008 study in South Africa, published in the Journal of Sexually Transmitted Infections, participants said they use word of mouth to find more welcoming clinics and avoid stigma. They also expressed a preference for younger healthcare providers because they tend to be less homophobic.<sup>26</sup>

## **For communicating PrEP, a focus on peer education may be recommended.<sup>12</sup>**

MSM surveyed in Kenya shared how they believe PrEP should be communicated to people like themselves. Answers included:

- Peer educators
- Community-based organizations
- Guidance counseling groups
- Seminars
- Mass media: radio, TV, billboards
- Instant messenger apps
- Leaflets

Instant messenger and SMS/text especially stood out as an effective channel and tactic for MSM.<sup>12</sup> When asked how PrEP should be communicated, MSM from the Kenya quantitative study cited instant messenger apps more than other audience groups. One study in Lima, Peru, found that sending periodic text messages to MSM encouraged them to test for HIV.<sup>47</sup>

## **In Kenya, some organizations use Facebook, WhatsApp, and other mobile engagement methods to reach MSM.**

To make initial contact with MSM, a number of organizations use mobile technology methods (prior to face-to-face communication) and advice interventions.<sup>40</sup> Organizations often use WhatsApp for group discussion or information exchange or one-to-one contact (often prior to physical outreach).<sup>40</sup>

These channels help maximize attendance at clinics by providing a greater sense of security. Secret passwords are used to enable MSM to access specialist services in mobile clinics without fear of discovery.<sup>48</sup>

Organizations can build Facebook group pages, either public pages or closed groups, to engage MSM and foster conversation. One way to identify new potential clients and build an online community is to track who has “liked” MSM-friendly posts.<sup>40</sup>

## **Mobile and online technology are valuable channels.**

Mobile technology should be explored for use in sending reminders, following up, and sharing information between health facilities across the border for clients who live a more mobile lifestyle.<sup>5</sup>

This approach also reaches MSM where they are often meeting one another. In Kenya, for example, MSM often meet at “hotspots” or house parties, but online dating and cruising sites (Grindr or PlanetRomeo) are also popular.<sup>47</sup> Depending on the willingness of a site to run advertisements or otherwise support a PrEP campaign, these online outlets may be a potential channel for communicating with MSM.

## **To reach MSM in person, meet them where they are.<sup>48</sup>**

Following the lead of MSM-supportive organizations, which have their own methods of outreach, may be valuable. For example, Kenyan organizations have an increased focus on peer-driven, behavior change communication through nontraditional outreach programs such as in nightclubs, hotels, and bars frequented by MSM.

## How to Reach and Connect with MSM: Best Tactics to Connect

### **Peer educators (other MSM) are critical to engaging this audience and gaining their trust.<sup>21</sup>**

According to the Global Forum on MSM & HIV, those HIV services that are targeted at and run by MSM have seen the greatest response and uptake.<sup>42</sup> The 2012 GMHR survey confirms that when MSM are unwilling or unable to visit an external clinic, peer-delivered services are effective alternatives.<sup>49</sup>

Training peers who are part of the MSM population to educate others, provide prevention commodities, and link people to MSM-friendly HIV services has been shown to effectively reach and engage this population. This prevention strategy works on the basis that there is an elevated sense of trust between members of the MSM population, which eradicates the fear of stigma.<sup>50</sup> Organizations staffed by MSM are also more credible and accessible to MSM.<sup>51</sup>

### **Connect through their influencers.<sup>40</sup>**

Communications may help sensitize leaders in the community, including religious leaders and local chiefs or elders, and in MSM's social circles to improve the enabling environment.<sup>40</sup>

### **Help redirect the public discourse on MSM away from stigma.<sup>20</sup>**

One organization found it effective to engage religious leaders, HIV organizations, healthcare organizations, and media in radio debates and other forums to help send anti-homophobic messages to the broader community.<sup>20</sup>

### **Deliver mobile information.**

Given the rise in use of mobile phone technologies, consider delivering intervention content that can be accessed on mobile devices. Consider short videos or podcasts that could either be downloaded independently by MSM or used by outreach workers to illustrate or describe HIV or STI prevention information.<sup>40</sup>

### **Partner with existing credible sources of sexual healthcare information.**

Community-based organizations (CBOs) play a key role in reaching MSM.<sup>49</sup> CBO-run clinics have helped MSM access services without facing stigma and discrimination, eased the financial burden of accessing HIV services, and provided tailored services that address the issues that MSM face.<sup>49</sup> CBOs also organize MSM support groups, which may offer opportunities for peer discussions and information dissemination. The 2013 study published in *Culture, Health, & Sexuality* reported that partnering with support groups offers an opportunity for organizations to reach MSM and provide them with accurate health information, sexual lubricants, condoms, and other health social services.<sup>33</sup>

Examples of MSM-serving CBOs include the following:

- **The People's Matrix Association in Lesotho** was established in 2008 when a group of 10 gay friends came together and formed what was known as the “discussion group.” It is now a recognized nonprofit organization, with members in all 10 districts of the country. It engages in public outreach through film screenings, radio programs, public gatherings, and social media.<sup>27</sup>
- **Out Well-Being in South Africa** delivers general health and mental health services to LGBT people.
- **The Centre for Popular Education on Human Rights Ghana** runs a drop-in center in Accra that offers STI diagnosis and treatment, HIV counseling and testing, and psychosocial counseling.
- **International Centre on Advocacy for the Right to Health in Nigeria** runs an MSM-friendly clinic focused on local healthcare providers who integrate with the community.

## **To further build credibility and trust, CBOs should seek to emphasize their roots within the MSM community and their MSM leadership.<sup>40</sup>**

Historically, CBOs led by LGBT people have spearheaded the response to HIV among MSM in sub-Saharan Africa. In recent years, some larger AIDS service organizations have begun to offer HIV programs to include MSM in the region. However, CBOs are still an important access point for MSM and HIV initiatives.<sup>49</sup>

## **Offer other support to address the complex challenges that MSM face.<sup>49</sup>**

Because their mental health may need as much attention as their physical health, offering MSM healthcare that is comprehensive in terms of addressing the whole human being may be a compelling way to engage them. MSM are also looking for places to socialize, learn, eat, commune, and work together (i.e., places where they can express themselves freely).<sup>49</sup>

Examples of this holistic approach may include:

- **Offering security and safety training.** One organization provides security training to teach members to assess daily risks and equip them with personal strategies to handle or avoid violence.
- **Offering mental health guidance and support.** Another organization delivers a strategic approach to intervention delivery that emphasizes holistic sexual health and well-being rather than focusing on disease prevention and treatment. Research from multiple country contexts indicates that this is a more effective approach, particularly for maintaining engagement with MSM over time.<sup>40</sup>

## **To Keep in Mind for Engagement in Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment**

### **A critical component of making an impact with this group will be involving healthcare providers.**

“Education of doctors is important. What the doctors know about PrEP is low—could make a big impact as it took a few starts to get on it; I needed tenacity.”<sup>46</sup>— MSM respondent, South Africa

### **Consider targeting MSM of lower socioeconomic status, who may not be as engaged in HIV prevention practices.**



The development of public health programs for MSM in sub-Saharan Africa requires sensitivity to the cultural and social conditions that shape HIV risk in this population.<sup>4</sup> A 2013–2012 nationally representative population-based survey in Kenya showed an association between HIV testing in the past 12 months and having a higher education, corresponding with other studies conducted in Ethiopia and Zambia. Researchers thus advised that intervention outreach efforts should target MSM of lower socioeconomic status (in Kenya) to improve their awareness of and engagement in HIV testing programs.<sup>52</sup>

### **Meet MSM where they are by integrating your efforts into existing services, such as drop-in centers.<sup>53</sup>**

Informal interviews conducted by Transcend Media Group in Kenya revealed that MSM regularly come into drop-in centers for condoms, lubricants, counseling, and HIV testing. Such sites might be useful places for engaging MSM about PrEP; after a 2016 meeting on PrEP for MSM in Africa, a number of international organizations (including UNAIDS and the World Health Organization) recommended that PrEP be integrated into sites that already provide HIV services.<sup>46</sup>

Similarly, a 2016 report from the SHARP program suggested that interventions may be more effective if they address not only HIV prevention, but also other topics of interest to MSM—such as sexual health, satisfaction, and pleasure.<sup>40</sup>

### **When possible, provide MSM not only with healthcare but also with the safe space, community engagement, and support they may severely be lacking.<sup>22</sup>**

Participants in the GMHR study reported that engaging with their community, in spaces where they feel safe, is helpful for those who feel isolated from their families and other social connections.<sup>49</sup>

## To Keep in Mind for Communicating PrEP

### **Address the side effects.**

Because the side effects of PrEP are a primary concern for MSM, communications efforts should explain the potential effects, their prevalence, and how to manage them.

### **Advocate for the continued importance and use of condoms.**

To combat the potential for MSM to use condoms less frequently because they are using PrEP, communications should emphasize the continued importance of condoms for STI prevention.

The research for the MSM profile was largely based on eight resources, including publications, reports, a meeting summary, and a policy document. Three of the resources were specific to Kenya (Midoun 2015; Olenja 2017; Kenya Human Rights Commission 2011), and the other five spanned Kenya, Lesotho, Swaziland, Uganda, Tanzania, Nigeria, Zimbabwe and South Africa (Arreola 2018; Stahlman 2015; Bourne 2018; PrEP for MSM in Africa: Meeting Summary and Next Steps Report 2016; Makofane 2014). Most methodologies included focus group discussions (FGD) or in-depth interviews (IDI); participants were MSM as well as advocates and policymakers. One report summarized a meeting in Johannesburg in April of 2016, in which advocates examined services available to MSM. Not all of the research reported demographic information such as age, but of those who did the mean age of participants varied from 22 to 32 years. Data gathering was conducted between 2010 and 2016.

## References

1. National AIDS and STI Control Programme (NASCOP). National Key Populations Communication Strategy 2014–2017. [Source](#). Published September 2014. Accessed December 22, 2018.
2. Muraguri N, Tun W, Okal J, et al. HIV and STI Prevalence and Risk Factors Among Male Sex Workers and Other Men Who Have Sex With Men in Nairobi, Kenya. *J Acquir Immune Defic Syndr*. 2015;68(1):91-96. doi:10.1097/QAI.0000000000000368.
3. Arreola S, Hebert P, Makofane K et al. Access to HIV Prevention and Treatment for Men Who Have Sex with Men. [Source](#). Published 2012. Accessed December 22, 2018.
4. Midoun M, Shangani S, Mbete B, et al. How intersectional constructions of sexuality, culture, and masculinity shape identities and sexual decision-making among men who have sex with men in coastal Kenya. *Cult Health Sex*. 2016;18(6):625-638. doi:10.1080/13691058.2015.
5. Olenja J. Report on the Findings of the Formative Assessment of the Cross-Border Health Integrated Partnership Project (CB-HIPP) Sites in the East African Region (Kenya). Published January 2017.
6. University of California, San Francisco. MSM in South Africa: Data Triangulation Project. [Source](#). Published 2015. Accessed January 3, 2018.
7. National AIDS Control Council. Kenya AIDS Response Progress Report. [Source](#). Published 2016. Accessed January 3, 2018.
8. Uganda AIDS Commission. The Uganda HIV and AIDS Country Progress Report July 2015–June 2016. [Source](#). Published 2016. Accessed January 3, 2018.
9. Lesotho Ministry of Health for UNAIDS. Global AIDS Response Progress Report 2015: Lesotho Country Report. [Source](#). Published 2015. Accessed January 3, 2018.
10. Ministry of Health and Social Welfare Tanzania, National AIDS Control Programme. Consensus Estimates on Key Population Size and HIV Prevalence in Tanzania. [Source](#). Published July 2014. Accessed January 3, 2018.
11. UNAIDS. Data 2017. [Source](#). Published 2017. Accessed January 3, 2018.
12. OPTIONS. OPTIONS Market Intelligence Report: Kenya. [Source](#). Published July 31, 2018. Accessed December 22, 2018.
13. Global Legal Research Directorate, Law Library of Congress. Laws on Homosexuality in African Nations. [Source](#). Published 2014. Accessed December 22, 2018.
14. Houttuin S. Gay Ugandans face new threat from anti-homosexuality law. *The Guardian*. January 6, 2015. [Source](#). Accessed January 3, 2018.
15. Kenya Human Rights Commission. The Outlawed Among Us. [Source](#). Published 2011. Accessed January 3, 2018.
16. HIV and AIDS in Zimbabwe. Avert website. [Source](#). Updated December 10, 2018. Accessed December 22, 2018.
17. Moyo J. Worse than dogs and pigs: life as a gay man in Zimbabwe. *Reuters*. September 3, 2017. [Source](#). Accessed December 29, 2018.
18. The Global Divide on Homosexuality. Pew Research Center website. [Source](#). Updated May 27, 2014. Accessed January 3, 2018.
19. The Other Foundation. Progressive Prudes: A survey of attitudes towards homosexuality and gender non-conformity in South Africa. [Source](#). Published 2016. Accessed January 3, 2018.
20. Safe space for gay men in Kenya. International HIV/AIDS Alliance website. [Source](#). Accessed January 3, 2018.

21. Stakeholder interview conducted for the OPTIONS Kenya Landscape Analysis. 2016
22. Shangani S, Naanyu V, Mwangi A, et al. Factors associated with HIV testing among men who have sex with men in Western Kenya: a cross-sectional study. *Int J STD AIDS*. 2017;28(2):179-187. doi:10.1177/0956462416638967.
23. Aroko G. What Is It Like Being Gay in Kenya? MTV Staying Alive. [Source](#). Published May 17, 2016. Accessed January 3, 2018.
24. Bureau of Democracy, Human Rights and Labor. Country Reports on Human Rights Practices for 2016. [Source](#). Accessed December 22, 2018.
25. Baral S, Burrell E, Scheibe A, Brown B, Beyrer C, Bekker L. HIV Risk and Associations of HIV Infection among men who have sex with men in peri-urban Cape Town, South Africa. *BMC Public Health*. 2011;11:766. doi:10.1186/1471-2458-11-766.
26. Lane T, Mogale T, Struthers H, McIntyre J, Kegeles SM. "They see you as a different thing": the experiences of men who have sex with men with healthcare workers in South African township communities. *Sex Transm Infect*. 2008;84(6):430-433. doi:10.1136/sti.2008.031567.
27. Stahlman S, Grosso A, Ketende S, et al. Characteristics of men who have sex with men in southern Africa who seek sex online: a cross-sectional study. *J Med Internet Res*. 2015;17(5):e129. doi:10.2196/jmir.4230.
28. King R, Barker J, Nakayiwa S, et al. Men at risk; a qualitative study on HIV risk, gender identity and violence among men who have sex with men who report high risk behavior in Kampala, Uganda. *PLoS One*. 2013;8(12):e82937. doi:10.1371/journal.pone.0082937.
29. Hladik W, Sande E, Berry M, et al. Men Who Have Sex with Men in Kampala, Uganda: Results from a Bio-Behavioral Respondent Driven Sampling Survey. *AIDS Behav*. 2017;21(5):1478-1490. doi:10.1007/s10461-016-1535-2.
30. Ndungu J. Capacity of Health Systems to Respond to the Health Concerns of Men who have sex with Men in Nairobi. [Source](#). Published May 2015. Accessed January 3, 2018
31. Gillespie N, Zaynab E, Darbes L et al. Coping mechanisms utilised by same-sex couples in Southern Africa, in the context of homophobia and HIV. Poster presented at: AIDS Impact; 2017; Cape Town, South Africa.
32. Van der Elst E, Gichuru E, Omar A, et al. Experiences of Kenya healthcare workers providing services to men who have sex with men: qualitative findings from a sensitivity training programme. *J Int AIDS Soc*. 2013;16(4 suppl 3):18741. doi:10.7448/IAS.16.4.18741.
33. Okall DO, Ondenge K, Nyambura M, et al. Men who have sex with men in Kisumu, Kenya: comfort in accessing health services and willingness to participate in HIV prevention studies. *J Homosex*. 2014;61(12):1712-1726. doi:10.1080/00918369.2014.951261.
34. UNAIDS. The Gap Report. [Source](#). Published 2014. Accessed December 22, 2018.
35. Folb L. Men who have sex with men shamed into risky behaviour. Independent Online. November 20, 2017. [Source](#). Accessed January 3, 2018.
36. Ndungu J. Capacity of Health Systems to Respond to the Health Concerns of Men who have sex with Men in Nairobi. [Source](#). Published May 2015. Accessed January 3, 2018.
37. Karuga RN, Njenga SN, Mulwa R, et al. "How I Wish This Thing Was Initiated 100 Years Ago!" Willingness to Take Oral Pre-Exposure Prophylaxis Among Men Who Have Sex With Men in Kenya. *PLoS One*. 2016;13(4):e0151716. doi:10.1371/journal.pone.0151716.
38. Bekker LG, Hosek S. HIV and adolescents: focus on young key populations. *J Int AIDS Soc*. 2015;18(2 Suppl 1):20076. doi:10.7448/IAS.18.2.20076.

39. Wells BE, Golub SA, Parsons JT. An integrated theoretical approach to substance use and risky sexual behavior among men who have sex with men. *AIDS Behav.* 2011;15(3):509-520. doi:10.1007/s10461-010-9767-z.
40. Bourne A, Fearon E, Nutland W. Mapping & appraisal of HIV prevention & care interventions for men who have sex with men (MSM) in Kenya, Tanzania, Uganda & Zimbabwe: A report of the SHARP programme. [Source](#). Published 2016. Accessed December 22, 2018.
41. Secor AM, Wahome E, Micheni M, et al. Depression, substance abuse and stigma among men who have sex with men in coastal Kenya. *AIDS.* 2015;29(suppl 3):S251-9. doi:10.1097/QAD.0000000000000846.
42. Men Who Have Sex With Men. Avert website. [Source](#). Updated August 7, 2018. Accessed January 3, 2018.
43. Bui TC, Nyoni JE, Ross MW, Mbwambo J, Markham CM, McCurdy SA. Sexual motivation, sexual transactions and sexual risk behaviors in men who have sex with men in Dar es Salaam, Tanzania. *AIDS Behav.* 2014;18(12):2432-2441. doi:1007/s10461-014-0808-x.
44. Tanzania Commission for AIDS. Global AIDS Response Country Progress Report. [Source](#). Published March 31, 2014. Accessed January 3, 2018.
45. Musinguzi G, Bastiaens H, Matovu JK, et al. Barriers to Condom Use among High Risk Men Who Have Sex with Men in Uganda: A Qualitative Study. *PLoS One.* 2015;10(7):e0132297. doi:10.1371/journal.pone.0132297.
46. PrEP for MSM in Africa: Meeting Summary and Next Steps Report. [Source](#). Published August 2016. Accessed January 3, 2018.
47. Bayona E, Menacho L, Segura ER, et al. The Experiences of Newly Diagnosed Men Who Have Sex with Men Entering the HIV Care Cascade in Lima, Peru, 2015-2016: A Qualitative Analysis of Counselor-Participant Text Message Exchanges. *Cyberpsychol Behav Soc Netw.* 2017;20(6):389-396. doi:10.1089/cyber.2016.0435.
48. This info was sourced from our partner in Kenya, Transcend Media Group
49. Makofane K, Beck J, Ayala G. MSM in Sub-Saharan Africa: Health, Access, & HIV. [Source](#). Published 2014. Accessed January 3, 2018.
50. PEPFAR. Technical Guidance on Combination HIV Prevention. [Source](#). Published May 2011. Accessed January 3, 2018.
51. Trapence G, Collins C, Avrett S, et al. From personal survival to public health: community leadership by men who have sex with men in the response to HIV. *Lancet.* 2012;380(9839):400-410. doi:10.1016/S0140-6736(12)60834-4.
52. Ng'ang'a A, Waruiru W, Ngare C, et al. The status of HIV testing and counseling in Kenya: results from a nationally representative population-based survey. *J Acquir Immune Defic Syndr.* 2014;66(suppl 1):S27-36. doi:10.1097/QAI.0000000000000102.
53. Interviews conducted by Transcend Media Group for the OPTIONS Kenya Landscape Analysis, 2016.