

Africa Region Human Development
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Targeting Vulnerable Groups in National HIV/AIDS Programs

*The Case of Men Who Have
Sex with Men*

*Senegal, Burkina Faso,
The Gambia*

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Foreword

In Africa, HIV/AIDS is spread overwhelmingly through heterosexual sex. Can, therefore, men having sex with men (MSM) be overlooked as a target group for HIV/AIDS programs without a significant negative impact on the programs' overall effectiveness? This study answers the question with a resounding "no" for two main reasons. First, MSM are much more prevalent in African societies than generally thought. And second, MSM are not an isolated group, but are in fact intensely and extensively sexually linked with the heterosexual members of African society.

Since the epidemic began, over fifty-million Africans have been infected by HIV, and each year three million more people are newly infected. The epidemic's destructive impact on Africa's human capital, productivity, public services, and social cohesion represents the paramount threat to the continent's development. AIDS has already claimed the lives of more than 20 million Africans. With the annual death toll of those infected by HIV/AIDS at 2.4 million and climbing, the impact of the epidemic is only in its early stages.

In response to the ravages of the epidemic, a number of donors are expanding their support for National HIV/AIDS Programs in Africa, including the United States, Canada, the Unit-

ed Kingdom, and the Global Fund for HIV/AIDS, TB and Malaria. In 1999, the World Bank committed a credit of US\$500 million to support national HIV/AIDS programs in Sub-Saharan Africa. This dedicated funding is known as the Multi-Country HIV/AIDS Program (MAP). The Bank made an additional commitment of US\$500 million in 2001 (MAP2), and is in the process of preparing future large commitments.

Although HIV/AIDS programming in Africa requires higher levels of funding, the current challenge is to spend existing funds efficiently and effectively to achieve the greatest possible impact. This desired outcome is not currently being achieved. HIV/AIDS is spreading like wildfire throughout Africa, and will continue to do so unless and until certain high-risk groups are no longer ignored. MSM remain one of these groups for several reasons. There is scant reliable data regarding the prevalence of MSM in Africa because of the taboo surrounding the practice. Incidental data indicate that sex among men is much more frequent than generally assumed. More importantly, this study confirms other research findings, namely that the sexual identity and sexual behavior of MSM only slightly overlap. In fact, the large majority of MSM do not identify

themselves as homosexuals, and furthermore, most of those MSM that were interviewed for this study acknowledge having had sexual relations with a woman during the last month preceding this survey.

As a result, even if homosexual activity is practiced by only five percent of adult males, any HIV infection acquired by this group will not be contained within the group, but can be spread to the rest of the population through heterosexual contacts. The homosexual and heterosexual circuits are closely inter-linked, and therefore, the cost to society of maintaining the taboo of same-gender sexual practices, and marginalizing people engaged in same-gender sexual contact is very high.

A prerequisite for an effective public health response is the recognition that MSM represent a high-risk group for spreading HIV. The inclusion of MSM in HIV/AIDS programming, however, may lead to wider acceptance of the group and may also help to lift some of the wider cultural taboos and stigma associated with HIV and homosexuality or same-gender sex. This study endorses the value of the human rights approach in achieving an effective HIV/AIDS program for MSM.

According to the World Bank's HIV/AIDS strategy, national HIV/AIDS programs can only be successful if they: (1) empower stakeholders with funding and decision-making authority; (2) involve actors at all levels of society, from individuals and villages to regions and central authorities; (3) provide support in

the public and private sectors and in civil society; and (4) encompass all sectors and the full range of HIV/AIDS prevention, care and support, and mitigation activities. Including MSM as a target group in all these areas of interventions is essential for the success of this strategy.

MSM are critical stakeholders in HIV/AIDS programs. Therefore the researchers who undertook this study not only analyzed MSM practices in a few West African countries, but they also established contacts between MSM groups and national authorities responsible for the fight against HIV/AIDS. In addition, in collaboration with MSM groups, the researchers also developed proposals for interventions, which could be financed by World Bank MAP1 and MAP2.

The research was carried out by a group of consultants under the leadership of Cheikh Ibrahima Niang, Social Scientist of the Institut des Sciences de la Terre, Université Cheikh Anta Diop of Dakar, Senegal. The study was initiated and managed by World Bank staff Kees Kostermans (Lead Public Health Specialist, AFTH2) and Aissatou Mbaye (Health Specialist, AFTH2). And it was financed by the Norwegian/Netherlands Gender Fund, which is managed by the Bank's Gender and Development Anchor of the Poverty Reduction and Economic Management Department (PRMGE).

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Abbreviations

ACI	Africa Consultant International
AIDS	Acquired Immunodeficiency Syndrome
ANCS	National Alliance against AIDS (Alliance National contre le SIDA)
ART	Anti-retroviral therapy
CBO	Community-based organization
CLNS	National AIDS Council (Conseil National de Lutte Contre le SIDA)
CTA	Center for Ambulatory Treatment (Centre de Traitement Ambulatoire)
DRADI	African Network for Integrated development (Réseau Africain pour le Développement Intégré)
ENDA	NGO for Environment and Third World Development
GIE	Grouping with an Economic Interest (Groupement d'Interet Économique). Often CBO for microfinance or income generating activities.
HIV	Human Immunodeficiency Virus
IPC/BF	Private Community Initiative (Initiative Privée de lutte contre le SIDA)
MSM	Men having sex with men
NGO	Non-governmental organization
OPALS	Pan-African Organization to fight AIDS (Organization Panafricaine de Lutte Contre le SIDA)
PA-PNLS	Action plan of National AIDS Program (Plans d'Action - Programme National de Lutte Contre le SIDA)
PLWHA	People living with HIV/AIDS
PNLS	Programme National de la Lutte Contre le SIDA (National HIV/AIDS Program)
RHADO	African Network for Human Rights Protection (Réseau Africain pour la Défense des Droits de l'Homme)
STI	Sexually transmitted infection
USAID	United States Agency for International Development

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Executive Summary

The predominant mode of HIV/AIDS transmission in Sub-Saharan Africa is through heterosexual contact. Epidemiological data is largely lacking on the transmission of HIV in Africa among men having sex with men (MSM). Most African governments vigorously condemn the practice of homosexuality or deny that it exists in their countries. However, recent studies have revealed the extent of homosexuality in Africa and the significant vulnerability of MSM to HIV/AIDS and other sexually transmitted infections (STIs). This study highlights the fact that the networks of MSM and those of heterosexual relationships are closely interlinked. It also highlights the violence and stigma to which MSM are subjected, and the limited access of MSM groups to prevention and treatment services for HIV/AIDS.

The main objective of this study, which was conducted in Burkina Faso, the Gambia and Senegal, is to develop innovative approaches that would include MSM in their nations' HIV/AIDS prevention and treatment strategies. The specific objectives of this project include:

- To determine the HIV/AIDS knowledge gap in the homosexual communities and the populations with whom MSM interact;

- To identify prior projects and programs that dealt with various aspects of sexual behaviors and the fight against HIV among MSM. The analysis of previous strategies and lessons learned could potentially be replicable in the three MAP projects;
- To identify relevant expert institutions and organizations with established experience to serve as regional resources in the target countries;
- To encourage institutions dealing with HIV/AIDS issues to incorporate MSM in their approaches and interventions.

This study's research methodology is ethnographic, and is coupled with participatory research for the purpose of developing action plans.

The data reveal a large variety of social structures in sexual relationships between men within the three countries under study. Of key importance is the conclusion that sexual behavior and sexual identity are not overlapping realities in these countries. Understanding the inherent diversity and complexity of identities and relations is a prerequisite for develop-

ing effective programs. The study of behavioral norms and codes of communication demonstrates that the symbols by which MSM identify themselves must be incorporated in messages of HIV/AIDS prevention in order to be effective.

Analysis of MSM vulnerability to HIV highlights the following factors: violence and stigmatization, precarious economic conditions, low awareness levels of STIs, indifference towards general prevention messages, and a very low condom use. In all three countries, MSM are ostracized by stigmatization from the available services for counseling and testing, treatment and care for STI and HIV/AIDS. In Senegal alone, a program has been implemented recently which aims at improving MSM's access to treatment and care of STIs and HIV. Burkina Faso is in the design phase of a similar new program for MSM, and in the Gambia the program is embryonic.

An analysis of MSM and HIV/AIDS prevention and treatment suggests three possible approaches: (1) a public health approach; (2) an approach based on human rights; and (3) a cultural approach. Short-term, mid-term and long-term strategies are derived from these approaches. The short-term strategy targets direct access to HIV/AIDS prevention and treatment services. The mid-term strategies focus on the integration of MSM in the design and implementation of projects and programs processes. Finally, the long-term strategies seek to improve the social and economic environment for MSM.

This study proposes specific strategies and budgeted plans of action for each country and recommends ways of building economic capacities in the various MSM networks. These plans are mainly intended as examples for other countries (See the annexes for details).

Introduction

Since the start of the HIV/AIDS epidemic, over fifty million people have been infected by HIV, and over twenty million Africans have died from AIDS. In the entire world, Sub-Saharan Africa is the area most affected by the epidemic. An estimated 28.5 million Africans are living with HIV/AIDS (UNAIDS, 2002)

The predominant mode of transmission of HIV in Sub-Saharan Africa is through heterosexual contact. Whereas in other parts of the world, such as North America, Australia, New Zealand, and Western Europe, male-to-male sex is considered to be the main mode of the virus's transmission. This mode of transmission is also true for South America, as several studies in Brazil, Argentina and Columbia demonstrated. Male-to-male transmissibility is also frequent in countries in Asia, such as Thailand, Indonesia and other industrialized Asian countries. This transmission pattern is increasingly evident in Eastern Europe as well.

Sub-Saharan Africa has scant epidemiological data on male-to-male HIV transmission, with the exception of South Africa. For the most part, Sub-Saharan countries have restrictive provisions in their legislations that condemn homosexuality or the governments deny its existence in their societies. Consequently, in

Africa inadequate documentation exists on the association between HIV transmission and male-to-male sex. Nonetheless, the few existing studies highlight the great risk and vulnerability for MSM in terms of their behavior and limited access to care and prevention services (Aggleton, 1996; Teunis, 1999; Niang, 2003). All studies present evidence that MSM face the threat of societal stigmatization, ostracism and violence. Surprisingly, tolerance and social integration of MSM does exist in some African societies, even in the prevailing culture of violence (Teunis, 1999; Niang, 2000).

In Senegal, under the auspices of the National AIDS program (PNLS), recent studies have laid the foundation for developing projects targeting MSM. And even though pilot projects are being implemented for MSM, the scope of these actions remains limited and MSM have few resources available to plan and execute their own responses to HIV/AIDS.

Some studies in Burkina Faso have documented MSM, but those have been mostly in ethnographic literature, and were not written in the context of AIDS, nor have they been updated since 1912 (Tauxier, 1912). This type of literature is nearly nonexistent for the Gambia, even though gay literature has mentioned meeting places (Gmunder, 1987). An analysis

of contemporary literature indicates that in the cases of the Gambia and Burkina Faso, as for most African countries, basic data on MSM are lacking. Therefore, important questions remain unanswered, such as: Who are the MSM? Where do they live? How are they organized? How can they be reached? How can they be mobilized?

In underdeveloped countries, MSM are not integrated in the prevention and treatment strategies for HIV/AIDS. In assessing the inclusion of MSM in prevention strategies, one study notes that only 25% of national HIV programs mention MSM as an important target group for prevention campaigns, and a mere 9% of them mention specific programs targeting male sex workers (Parker et al., 1998). The actual number of those strategies targeting MSM that are actually implemented is an issue in and of itself.

The three countries studied in this report—Burkina Faso, Gambia and Senegal—fare differently in terms of their HIV/AIDS epidemiology. In Burkina Faso, the prevalence of HIV is rapidly increasing; it is estimated at 6.5% in adults. Senegal has a HIV prevalence of 1.5% in the adult population, while the Gambia, at 1.6%, has only a slightly higher prevalence. Among youth aged between 15 and 24, estimates of prevalence range between 3.2% and 4.7% for Burkina Faso; 0.3% and 0.7% for Gambia; and 0.1% and 0.2% for Senegal. Surveillance data have been collected on high-risk populations such as prostitutes and STD patients in all three countries, but no data have been collected on the prevalence of HIV among MSM.

All three countries have adopted a multi-sectoral approach to fighting HIV/AIDS, which includes community responses. The governments have forged partnerships with a number of non-governmental organizations (NGOs) and community-based organizations (CBOs). Among the activities of the NGOs and CBOs are awareness campaigns, training, voluntary counseling and testing (VTC), medical follow-

up of persons living with HIV/AIDS (PLWHA), monitoring and evaluation, planning, advocacy, distribution and sale of condoms, microfinance and sentinel surveillance. Despite all these activities, MSM are not included in those partnerships nor are they considered a target group for services.

In contrast to the other two countries, Senegal has responded quickly and effectively to the HIV/AIDS pandemic. The government engaged in dialogue with political and religious leaders and developed a consensus approach in planning its response against HIV/AIDS. The government's dialogue with religious figures successfully deflected their opposition to the use of condoms as one means of preventing the spread of HIV. In many other African countries, religious leaders remain opposed to the use of condoms. Currently, there are programs throughout Africa that seek to mobilize religious figures in the fight against HIV/AIDS. Nonetheless, those programs have done little to address MSM, and religious arguments often have been used to justify violence and stigmatization against MSM.

MSM have not been significantly included in the prevention and treatment programs for HIV/AIDS in Africa or other parts of the developing world. As this study shows, programs for MSM in Senegal have been insignificant and nonexistent in the Gambia and Burkina Faso.

The exclusion of MSM as a target group in HIV/AIDS programming has led various international organizations, such as the World Bank, to formulate responses that seek to incorporate MSM in the fight against HIV/AIDS. The following strategies and recommendations are a result of UN organized meetings.

- Advocacy to promote a greater awareness of the circumstances (e.g. the army, boarding schools, prisons, gay communities etc.), the social and demographic profiles (unmarried, married, young adults),

sexual orientation (homosexual, bi-sexual), and the driving forces (economic, financial, material, emotional etc.) associated with male-to-male sex;

- Promotion of self-assessments by MSM communities of their risk and vulnerability factors and their needs for HIV/AIDS prevention and awareness, especially through peer education and condom promotion;
- Conducting pilot projects that would raise the visibility of MSM and their rights in Africa, Asia, Central Europe, in light of human rights and international campaigns against stigmatization and discrimination with regards to access to prevention and care for HIV/AIDS;
- Conduct reviews of policies and legal instruments to address the vulnerability of MSM to HIV/AIDS;
- Documenting culturally appropriate programs for prevention and risk reduction as well as access to treatment and care;
- Developing appropriate methods for epidemiologic surveillance of MSM.

In response to the spread of HIV/AIDS in Africa, the World Bank initiated the Multi-Country AIDS Program (MAP) to mobilize resources to prevent the spread of the pandemic and to reverse its course, particularly in Africa. The overarching goal of the MAP is to increase access to prevention treatment and to care services, particularly for the most vulnerable populations, while reducing the impact of HIV on the public and private sectors, communities and families. As a vulnerable population, MSM are often mentioned as a target group in MAP projects. In reality, however, very few if any funds have been devoted to support activities for MSM.

Because MSM represent a high-risk group for the transmission of HIV, but have been generally excluded from supportive activities, the main objective of this study is to develop innovative approaches that would include MSM in national strategies for HIV prevention, treatment and care of HIV/AIDS.

The specific aims of this study are the following:

- To determine the knowledge gap about HIV/AIDS in the MSM communities and the population with which they interact;
- To determine the acceptance for voluntary counseling and testing (VCT) by MSM;
- To identify projects and programs that have already dealt with various aspects of sexual behavior and the fight against HIV/AIDS among MSM in order to analyze their strategies and to draw lessons from their experience;
- To identify expert institutions and organizations working on these issues in the three countries that may serve as regional resources;
- To encourage agencies working on issues of “gender and HIV/AIDS” to incorporate MSM in their approaches and interventions.

To achieve these objectives, a team of African researchers conducted exploratory studies and participative research in three West African countries. All three countries receive World Bank support under the MAP. Current debates on interventions in the fight against HIV/AIDS in Africa guided the researchers. Earlier studies sponsored by UNAIDS were heavily relied upon, particularly in the following domains:

- Existing policies for the social and political environment of individual and community rights;
- Social status and economic conditions that drive the factors of vulnerability and the capacity to respond to HIV/AIDS;
- Culture and traditions and their impact on thinking and behavior of groups, communities or society, and the extent to which they represent social consciousness;
- Gender interactions encompassing the social constructs of masculinity and femininity;
- The role of spirituality and religion in formulating the goals and values of individuals, groups and societies.

The researchers combined ethnographic methods and participatory research in order to generate action plans for MSM groups with whom they worked. The ethnographic work sought to clarify the social contexts and structures associated with male-to-male sex in order to integrate those findings into the HIV/AIDS strategy. Researchers used a standard rapid research methodology of sites observation, non-structured interviews, and focus group discussion. The participatory research sought to establish the appropriate dynamics that would enable the various MSM groups to formulate strategies and actions. In all three countries, the ethical implications of the study and its confidential character were amply discussed and agreed upon with MSM groups as well as with other interested groups.

In Burkina Faso, the researchers in Ouagadougou relied on NGOs and other associations such as “Vie Positive” and “Association of African Solidarity” to establish contact with MSM groups and to facilitate interviews and focus group discussions. The ethnographic observations and three focus group discussions

collected data on the social conditions of MSM, their health problems, and their need for information about HIV/AIDS, STIs and condom use. After the data collection, the activities stemming from MSM’s initial recommendations were further developed towards an action plan over the course of several meetings.

In the Gambia, the first contacts with MSM were facilitated by Senegalese MSM who had been part of the study in Senegal and who are in frequent contact with MSM from the Gambia. Site observations, interviews with individuals and group discussions were conducted in Farafégné, Bansan, Soma, Baseé, Banjul and Fadjará. Working group discussions also took place in Dakar, Senegal, with MSM from the Gambia and MSM from Senegal. Gambian women who interact with MSM were instrumental in establishing contacts with MSM community leaders and organizing group discussions. The National AIDS Secretariat (NAS) took the lead in formulating the work plan for the Gambia.

In Senegal, the study was conducted in Dakar, with some visits to Kaolack, Saint-Louis, Thiès and Mbour. These visits coincided with the establishment of baseline evaluation parameters by the National AIDS Control Program (CLNS) in collaboration with the Population Council’s Horizons Program. The research team held several meetings with key “influencers” within the MSM community. These meetings led to the organization of a four-day workshop that brought together to develop strategic plans various MSM groups and people who identify with them. Several of the workshops focused on building life skills and role-playing to improve self-esteem.

This report consists of the following parts:

- The overall ethnographic context of male-to-male sexual relationships;
- An analysis of the social conditions of MSM in the Gambia, Burkina Faso and Senegal. This analysis also presents vul-

- nerability factors and MSM-targeted programs;
- Suggested approaches and strategies to improve MSM access to HIV/AIDS prevention, treatment and care services;
- An annex with country-specific logical frameworks and budgeted action plans.

Social Situation of MSM in The Gambia, Burkina Faso and Senegal

The major determinants of MSM behavior, including self-identity, norms and social interactions or socio-economic context, must first be considered and understood in order to develop appropriate interventions for and with MSM. The ethnolinguistic approach of this study can highlight these attitudes, images and identity. Revealing these determinants in social interactions is essential for assessing the MSM risk environment and for establishing a basis for targeted programs.

Identities and Social Interactions

Two major observations can be made from the ethnographic data:

- All local languages differentiate between “penetrating” and “receptive” MSM identities (“tops” and “bottoms”);
- MSM employ terminology to identify themselves, and their designations differ from the terms society generally uses to identify MSM.

Designation by “Others”

The terms most frequently used to identify MSM describe those men who are perceived to occupy the receptive position in sexual relations. Those terms usually designate parts of the body, physical traits or mannerisms usually associated with the female gender. Among the Wolof tribe in Senegal and the Gambia, the term *goor jigen* literally translates to “man/woman.” Similar terminology is found in Burkina Faso where the terms *pougindaogo* in the Moore language and the term *kiété mousso té* in the Dioula language describe a simultaneous presence of a man and a woman or the negation of man or woman in one individual: “neither man nor woman.” Sometimes terms describe female attributes. In Burkina Faso, the term *za* is used, which means a pronounced sense of style and fashion usually associated with the female gender. Other terms may describe the absence of masculine traits such as virility, firmness, rigor, toughness, etc. Similarly, terms from the animal world associated with the absence of virility are also used. In Wolof, the term *sax* (earthworm) describes a lack of vigor, firmness and toughness. In Sene-

gal, the analogy with the prominent buttocks of a duck serves to describe men in the receptive role in sexual interaction, when the term *canara* is used. In urban areas, terms such as “homo”, gay or *pédé* are gaining currency. These also relate almost exclusively to men in the receptive role in sexual interaction.

Terms used to designate receptive males usually do not apply to penetrating males. In Wolof, the term *goor jigen* would not describe the penetrating partner. He may sometimes be called *faaru goor jigen*, literally meaning “lover of a man-woman.” That term refers more to the relationship than to his ontological identity. The receptive *goor jigen* is defined essentially as a man-woman, whereas his partner is characterized viewed as masculine. The researchers did not find terms that encompassed both the concept of receptive and penetrating partner in any of the local languages. Understanding the distinction between these identities is essential in formulating messages that specifically target each identity.

In situations of high male concentrations and promiscuity, such as prisons, armies or boarding schools, sex does occur among men. In those cases, normal societal categorizations are not those that are utilized. In that context, the form of the sexual act is likely described by terms such as violent acts, individual rape, collective rape, or by the nature of the relationship: one member is called “husband” and the other “wife.”

Ethnographic studies have highlighted the specific roles played by certain categories of MSM in traditional ceremonies in Senegal, the Gambia and Burkina Faso. Those individuals are not referred to by their sexual orientations but rather by the roles they play in those ceremonies. In traditional Senegal dance troops, *simb* or lion dancers, are exclusively male. Often MSM disguised as women play feminine roles such as the lioness in the lion dance.

Women may play an important social role for MSM. In some women-led social groups,

men may have subordinate roles. Some MSM fulfill roles associated with their identities such as *goor jigen*. For example, in Burkina Faso, MSM are involved in baptisms, marriages, traditional dances and cultural activities. In those ceremonies they wear feminine disguises. In Senegal and the Gambia, special relationships exist between groups of MSM and influential powerful women, who are called “bosses”. These “grandes dames” are known as *jeggu-ibbi* or *meru-ibbi*, mother of *ibbis*. They offer protection, room and board to *ibbis* having problems. Their homes may serve as meeting venues for *ibbis*. These relationships between MSM and women are characterized by friendship, trust and solidarity. An informant in one focus group stated: “Most of my friends are women. I trust them and they trust me. And that allows us to discover things about men and to live our femininity.” In all three countries, MSM play a significant role in occupations of hair styling, fashion, and cosmetics.

Ethnographic studies of MSM in the Gambia indicate an important role played by lesbians. MSM can be close to lesbians for emotional support and financial assistance in case of need. The wide array of situations and the complexity of identities and the roles played by MSM in their communities must be considered when developing comprehensive responses for MSM.

Peer Designation

MSM consider the term *goor jigen* “man/woman” to be discriminatory and charged with violence. A Senegalese MSM stated: “The term *goor jigen* frightens us. When spoken in our presence, we shake. This term is a signal that wild mobs are about to unleash insults, blows, and hurled stones at us.”

Within MSM communities, men in the receptive role prefer to call themselves *ibbi*. *Ibbi* literally means, “to open up.” It is associated with the idea of receptivity in sexual rela-

tionships. This term is also used in the Gambia in addition to the equivalent word *tchodo*. *Tchodo* is also used in the “freetonian” community, which includes refugees from Sierra Leone, Liberia and Nigeria. In Senegal, since the Population Council published its study, the term MSM is gaining currency in designating men in the receptive role. The term is fashionable and easy to pronounce.

Ibbi is distinguished from the term *yoos*, which is used for the penetrating partner. The duality *ibi-yoos* is used in the Gambia and Senegal, and employed with a different pronunciation such as *woubi* and *yossi* in Burkina Faso. The term *folles* indicates the receptive partner and *coco* or *mec* the penetrating partner in Burkina Faso. The MSM community uses codes to differentiate the active *coco* or *mec* from the passive *folle* and the dual role or bi-sexual individuals.

The term *yoos* may also describe a group of individuals who commonly practice penetrating sex. This idea of community is also present in Burkina Faso where the term *family* is used. For instance, one may talk about “a member of the family” to indicate the receptive sexual identity. In the Gambia, one uses the term *askoun*, meaning lineage or clan. In designing interventions, it is important to incorporate the references to the community and inter-communal relationships.

Behavioral Norms and Modes of Expression

This study’s key observation is the disconnect that exists between sexual practice and sexual identity among MSM. Although sexual identity suggests certain sexual practices and behaviors, it is also true that certain behaviors are not exclusive within the assumed identity and often exceed the framework of that identity. In other words, MSM often do not identify themselves as gay or as having exclusively homosexual behavior. Clearly, locally defined terms

such as *gay*, *MSM* or *goor jigen* have limitations, since they only indicate receptive partners or those considered as such. Because MSM sexual identities, practices and behaviors are not rigid, both receptive and penetrating MSM also engage in sexual relationships with women. A study conducted by the Population Council in Senegal reports that 85% of MSM had sex with a woman during the month preceding the survey. In a more recent Senegal study, 99% of MSM reported having had sex with a woman. In Burkina Faso, some qualitative studies have indicated that the majority of MSM appear to have bi-sexual behavior. In all three countries in fact, a significant number of MSM are married to women. Marriage serves as a means of fitting into the social norms, and of hiding sexual preferences that are considered outside the norm.

In addition, sexual relationships may exist without being admitted socially or even without being recognized, assumed or accepted individually. The gap between behavior and identity is socially and individually determined by intrinsic norms, values, concepts and interactions. In several communities in Senegal, the Gambia and Burkina Faso, a male-to-male sexual relationship is considered a highly personal and private affair that requires the highest level of protection, privacy, discretion and “veil.” The Wolof people of Senegal and the Gambia use the concept *soutoura*, which is a social reference to tolerance, acceptance and protection, for this type of relationship between men. Some MSM explained that it is a necessary protection against violence and rejection that ensues after any revelation of homosexuality. In that context, the relationship of MSM to society is guided by a certain level of respect that forbids anyone to speak out, intervene or comment on the intimate life of the MSM. “Everyone knows that such person has sexual relationship with another person of the same sex but no one would openly mention it.”

Behavior and sexual identity are not easily analyzed outside the sexual social context.

Often codes, symbols and signs or metaphors are used to convey the message and can integrate the many facets of an individual or social phenomenon. “When two *ibbi* meet in a bus, they recognize each other easily and instantly. The clothes they wear could signal their belonging to an *ibbi* family. But clothing alone is not enough to recognize an *ibbi*. You know, many people wear the large *booboo* for the Muslim Friday prayer. So, if an *ibbi* so desires, he may wear the same *booboo* and exhibit the same masculine attitude as any other faithful on his way to prayer. But, when he wants to communicate with another *ibbi* in the mosque, he has a particular way of moving the sleeve of his *booboo* or swinging his hips, or rolling his eyes to indicate in a singular way that he shares the same community of sexual preference.” Therefore, while explicit messages are clearly important in preventing HIV/AIDS, it seems just as important to integrate symbols in messages targeted at MSM with which they self-identify.

However, MSM that both hide and implicitly reveal their sexuality may carry a psychological burden. Sometimes MSM may explicitly reveal their sexual orientation unequivocally through gestures or words, especially those MSM considered to be receptive partners. In Senegal, the term *taccu* is used to signify “to applaud”—traditionally you applaud publicly to promote an event or to reveal something that has been hidden up until that moment.

Vulnerability Factors

Violence and Stigmatization

In all three countries, MSM who are considered receptive partners experience rejection, stigmatization and violence that may increase their vulnerability and risk for contracting HIV/AIDS. The family is one of the first circles where especially receptive MSM partners experience stigma and violence. Intimidation,

insult, verbal violence and psychological pressure from within the family are frequent. The family may even exclude a MSM family member from the household. In the initial study done in Senegal, nearly half of the 250 MSM interviewed reported that they had experienced verbal aggression, insults and threats from their families. In Burkina Faso and the Gambia, data suggest in most cases that families tend to ignore an MSM family member. Even when family members heard about incidents, they would continue to feign ignorance until confronted by tangible and irrefutable proof. But, when such proof surfaces, the MSM’s family becomes the first source of homophobic violence. The level of violence is equated with the degree to which the family views its honor as having been disgraced by the behavior of one of its members. In Burkina Faso, reports exist of MSM having been beaten, publicly disrobed or otherwise humiliated by members of their own families. One informant revealed: “Someone sent an anonymous letter to my mother telling her that I was prostituting myself to men. My own mother threatened to kill me with her own hands to preserve the honor of the family if it turned out to be true.” Ostracism is another frequent reaction by families. MSM are excluded from any network of communication, consultation or decision-making. Some may never be spoken to again by their families or only in the most limited fashion.

MSM also experience society’s violence through insults, disdain, blows, physical aggression, stone throwing, etc. Many MSM have reported physical abuses including: being struck, blows, and suffering stones being thrown at them by their own families, community members and even the police. Reportedly in some neighborhoods in Senegal young people will collect and start throwing a “rain of stones” when an *ibbi* passes through. In the Gambia, violence against MSM may be linked to financial motives. “People think that we have a lot of money when we go out with our

clients so they wait till we are alone to attack us.” Police raids against MSM were frequently mentioned in Senegal and Burkina Faso. The police in Burkina Faso were even accused of assisting the local press in publishing photographs of MSM that they had arrested.

In the Gambia, MSM harbor a real fear that brutal state-sponsored violence that is used against commercial sex workers and women who use skin-bleaching cream could easily be turned against them. Official government statements violently decry behavior that is considered sexually deviant. As a result, MSM are suspicious and fearful of public institutions, including those in charge of combating the HIV/AIDS epidemic.

Many MSM also experience sexual violence among themselves. A study conducted in Senegal noted that the lives of many MSM are characterized by violence and rejection; 43% of MSM stated that they had been raped at least once outside their home, and 37% within the past twelve months. In Burkina Faso, one informant stated: “I had my first sexual experience at the age of fifteen. It was very painful because it occurred during a rape. I was having a good relationship with two adult males whom I trusted. One evening in a classroom one of them grabbed me, tied me up and prevented me from screaming; what was going to happen happened.” In Senegal, several MSM accused members of the police force of sexual violence against them; 13% reported having been raped by policemen.

Violence emanating from the community or from the police force is often accompanied by highly homophobic speech in religious associations, as in Senegal, or for political gain, as in Burkina Faso. The dominant religions in all three countries formerly reject male-to-male sexual relationships. The Senegal report noted: “Because the Muslim religion forbids homosexuality, we do not accept homosexuals in our house nor in our mosque. When one of them dies we refuse to pray over him. Recently, in fact some young people in one neighborhood

opposed the burial of an MSM in the local cemetery.” In spite of those official positions, many MSM are actively involved in religious associations called *dahiras*. Some may work in the kitchen of these associations, or perform tasks normally carried out by women during the associations’ meetings. Other MSM attempt to justify their sexual identity by trying to establish a genealogical link between themselves and biblical figures, especially the prophet Lhot.

However, there are places or occasions where MSM are tolerated and protected socially. In several traditional *Lébous* neighborhoods of Dakar, the *ibbi* enjoy the protection of the entire community. One informant stated: “Nobody dares insult an *ibbi* who belongs to the community. He gets the protection usually extended to the insane. If you hear that someone has thrown stones at one of them, you can be sure that that person was not from the neighborhood.” In the Gambia, MSM organize traditional dances and ceremonies known as *taneber*, which are not only tolerated, they are quite appreciated in some localities. In Senegal, however, such practices would not be tolerated.

Sometimes, MSM may enjoy certain social advantages. *Ibbi* have sex partners in all social strata. Some even have managed to establish a high-class clientele of religious leaders, businessmen, wealthy men, tourists, international aid workers, etc. These strata are out of the reach of the ordinary man. The *ibbi*’s sharp tongue and capacity to insult, which are used as a defense mechanism, are proverbial. It is said, “When a *goor jiggen* opens his mouth, even God shuts his ears.” An *ibbi* may threaten to expose publicly a sex partner who wishes to keep the relationship concealed. This disclosure is called *siwal* or *tojal*.

Economic Conditions

Poor economic conditions create vulnerability. In all three countries, MSM are involved in commercial sex. Sexual relationships among

men form an important part of prostitution. In this context, receptive MSM exercise weak leverage in negotiating condom use by clients. Unemployment, economic vulnerability and poverty are associated with multiple partners and lack of condom use. The sexual relationship is unequal due to the MSM's material and financial dependence. The weaker partner may think that achieving his goals or social agenda depends on the dominant partner.

In both Senegal and the Gambia, those areas favored by tourists—Petite Côte in Senegal and the beaches in the Gambia—attract high numbers of MSM involved in commercial sex. Western tourists are believed to seek out very young partners considered to be “virgins” and therefore uninfected with HIV. These young partners often pretend submissiveness, ignorance or innocence, making the negotiation of condom use all the more difficult. In all three countries, the number of street children is increasing. This group is becoming increasingly vulnerable to risky sex practices. But no HIV prevention and treatment program covers boys and young men who engage in male-to-male sex.

There are some MSM who are well off, if not affluent. In fact, the study's researchers conducted many of their interviews in Burkina Faso with members of the social elite.

MSM Knowledge of STIs and HIV/AIDS and Their Attitudes towards Condoms

The survey in Senegal highlighted that MSM had a scant knowledge about STIs. They seldom link STI symptoms to a pathogen. Rather, they believe that the symptoms are a result of physical damage from violent sex acts: *naw bi dafa tepeku*, literally meaning “anal tears.” MSM in the Gambia and Burkina Faso shared similar beliefs.

In all three countries, however, most MSM seem to know the main HIV transmission modes. Almost all have been exposed to HIV

awareness campaigns. In a study conducted in Senegal, nearly all 250 MSM interviewed recognized that HIV could be contracted through sex, and more than 80% of them mentioned condoms as an effective means of prevention, although the proportion of those who said they used condoms was far less.

In Senegal, as in Burkina Faso, most MSM do not feel at risk for HIV infection and believe that the prevention messages are not intended for them. Indeed, the prevention messages are targeted almost exclusively at heterosexuals. A recent study conducted in Senegal by Family Health International noted that adolescents generally believe that HIV could only be transmitted through heterosexual contact, especially with prostitutes, and not through male-to-male sex.

In all three countries, there is a low level of condom use by MSM. The Senegal survey revealed that among the 250 MSM interviewed only 23% used a condom during their last penetrating sexual act and 14% during their last anal receptive sexual act. Apparently, in all three countries, the power to negotiate condom use varies with the receptive or penetrating identity. Receptive partners tend to have less power: “There is nothing an *ibbi* can do if a *yoos* decides not to use a condom. Often we feel obliged to accept unprotected sex out of love for our partner lest we risk losing him.”

Frequently MSM complain that condoms irritate the anal mucosal lining are of dubious quality and often tear. They said that good quality condoms were difficult to find and prohibitively costly for regular use. In the Gambia, many MSM obtain high quality condoms and lubricants from Senegal. In Burkina Faso, MSM indicated that they often use shea butter, vaseline or beauty cream as lubricants. But those products are not recommended for use with a condom because they degrade its quality. Although good quality lubricants are sold in pharmacies, purchasing these items risk exposing an MSM's sexual identity with concomitant security consequences. Some NGOs in

Senegal have managed to introduce condoms and lubricants of good quality within the MSM network.

Access to Healthcare and Treatment of STIs

Surveys in Senegal and exploratory research in the Gambia and Burkina Faso indicate that stigma associated with receptive sexuality often has forced MSM to self-medicate when they have contracted an infection. In Burkina Faso, most focus group participants indicated that they do not seek medical care when infected with an STI. In all three countries, visits and communication with healthcare staff carries the risk of exposing one's practices or being stigmatized by sexual identity. Receptive MSM are particularly reluctant to reveal any anal pathology to healthcare staff. This attitude is linked to fear of being rejected or to a lack of trust in the healthcare system. "It is a shame to explain this type of disease because you fear being rejected or that your sexuality may be revealed." Self-medication for STIs is quite prevalent; practices include sitting in warm water, using antiseptic solutions sold over the counter or using traditional products such as shea butter. In the Gambia, one informant stated: "When I have an anal infection, I just tighten up my ass and I wait until it heals."

From the beginning of Senegal's National Program to Fight HIV/AIDS (PLNS), the control of STIs has been integrated in the overall HIV/AIDS prevention strategy. This integration occurred at the same time that the syndromic approach began to be used to treat STIs. Algorithms and didactic materials, training guides, and posters were designed for that purpose. Healthcare workers at various levels were trained to combine their treatment and advice to patients with the distribution of condoms and partner notification. However, homosexual relationships do not at all feature in those algorithms or training manuals.

In 1969, Senegal legalized prostitution and began to manage the social and medical needs of sex workers as part of the national health policy. Corresponding programs are based in a referral center at the Institute of Social Hygiene in Dakar and also in regional and district centers throughout the country. Medical evaluation includes medical and gynecological exams, with microbiology and blood work to screen for HIV/AIDS and treat STIs. Free distribution of condoms is part of the program. In addition, medical and psychological care is provided to HIV positive patients. This policy only targets female sex workers, however. Male sex workers are virtually ignored by the STI care structures.

As in most African countries, Senegal does not offer a specific program targeting MSM. Limited initiatives have come from a small group of concerned physicians in an attempt to generate an adequate response. In Burkina Faso the NGO "Vie Positive" has reportedly established a welcoming system to receive and care for MSM. Nonetheless, these programs in Burkina Faso and Senegal are woefully inadequate to serve the potential demand for treatment and care.

Access to Counseling and Testing Services and Treatment of HIV/AIDS

Nearly all participants in the discussion groups in Senegal, Burkina Faso and the Gambia stated that they did not know their HIV status. Admittedly, they are reluctant to go for voluntary counseling and testing. This is partly because if diagnosed as HIV positive, care and treatment resources are scarce, and partly for fear of being rejected by their families. Such feelings of powerlessness and abandonment could be mitigated if anonymity and confidentiality were guaranteed and if counseling and treatment were provided as proclaimed in the official national HIV/AIDS policies.

Often, MSM are uninformed and socio-cultural barriers prevent them from accessing cer-

tain services, when they are available. In 1997, the government of Senegal committed itself to making anti-viral medication available and accessible to improve the quality of life of people living with HIV. Senegal launched the Dakar-based “Initiative to Access Anti-Viral Medication” (ISAARV) on August 1, 1998. Since 2002, the regions of Thiès, Saint-Louis, Kaolack, and Louga have benefited from therapy centers. Generally, a technical team determines the appropriateness of starting the therapy for a patient. Health services for HIV/AIDS patients, including psychosocial care and treatment and prevention of opportunistic infections, are available in all university and regional hospitals, and in district health centers. Efforts are being made to make anti-viral therapy ever more widely available and accessible. All eleven regions have a laboratory and trained personnel to diagnosis HIV. There are anonymous screening centers and voluntary testing sites that provide free care in the regions. However, little was done to make those services attractive enough for MSM who fear stigmatization when they contact the healthcare system. No programs or activities exist to sensitize healthcare workers to the need of reducing the stigma of MSM, and there are no specific programs aimed at improving MSM’s access to ARV therapy. At the same time, MSM need to be made aware that they could receive treatment at the general centers in strict privacy and confidentiality. Given their current marginalization, it is quite likely that few treatment services are really available to MSM.

For all patients receiving ARV therapy, treatment requires laboratory analyses, such as CD-4 count, viral load and other biochemical tests. The patient must pay for all these tests. This is a major burden for individuals of very modest means. Also, good nutrition is an essential requirement for patients. Many physicians in Senegal think that most MSM patients cannot afford the proper nutrition needed to support ARV treatment.

In Senegal, specialists recognize the need for psychological support as an important component of HIV/AIDS treatment. However, social workers and psychologists are inadequately trained to respond to the specific needs of MSM. Consequently, HIV-positive MSM carry the double burden of maintaining the secrecy of their sexual orientation and their HIV status. According to a specialist: “They lead a double life to avoid a double stigma.” This can block their compliance with any treatment.

Burkina Faso and the Gambia also have counseling and testing services and treatment infrastructure for AIDS patients. Healthcare workers confirm that they often suspect homosexuality when they encounter certain pathologies affecting the patient’s anal mucosal lining. At the same time, they recognize the absence of appropriate structures to screen, communicate with, and care for MSM patients.

In interviews with PLWHA, the fear of rejection is often mentioned, but rejection is even more profound when the HIV-positive person happens to be MSM. Reports from all three countries describe MSM who are HIV-positive as often completely destitute and lacking any psychosocial assistance. They frequently are abandoned in hospitals or at home following a diagnosis of AIDS. Relatives are often the first to abandon the patient. Their sole source of support is then other MSM friends or *meru-ibbi* and *jeggu-ibbi* who serve as companions and provide social, financial and material support. However, in the case of the Gambia and Senegal, there are reports of *meru-ibbi* and *jegu-ibbi* who have managed to convince religious leaders and other key influencers to preside over the funerals of MSM who died of AIDS.

Programs Targeting MSM

Burkina Faso and the Gambia do not seem to have any specific HIV/AIDS prevention and

treatment programs targeting MSM. However in Burkina Faso, some NGOs interact with MSM with AIDS. One of them is the Association of African Solidarity (AAS), which includes some MSM in its client pool of PLWHA, and the above-mentioned *Vie Positive*, an NGO that offers confidential care and psychosocial support to MSM. As a result of a study sponsored by the PNLS and supported by the Population Council's Horizons Program, Senegal has designed a new program that is currently being implemented through the Ministry of Health.

The Program to Improve MSM Access to STI and AIDS Care in Senegal

The main objectives of that program are the following:

- To improve MSM access to prevention of STIs and HIV/AIDS;
- To improve access to STI diagnosis and treatment and access to AIDS treatment;
- To implement an awareness campaign for the media, administrators and healthcare providers and associated public services.

The main components include:

- Information/communication for behavior change and risk reduction of STIs and HIV;
- Healthcare services, support and treatment for STIs and AIDS;
- Advocacy towards social and professional groups that interact with MSM, including healthcare personnel, communication specialists, law enforcement, etc.;
- Monitoring and evaluation of those interventions.

COMMUNICATION FOR BEHAVIOR CHANGE AND RISK REDUCTION OF STIs AND HIV

In Senegal, current strategies underway for MSM include: fostering healthcare seeking behavior; creating information exchange networks; and carrying out awareness campaigns about where to obtain condoms and water-based lubricants, e.g. pharmacies, clinics, hospitals, health centers and mobile stores. The strategies also encourage MSM to use condoms consistently and to avoid unprotected intercourse. Many MSM fear that their sexual orientation and practices will be revealed and exposed. Their fear hinders their participation in activities designed to provide information and sexual health services. To address this issue, additional efforts and special campaigns organized by MSM associations and networks have been planned for those MSM who are reluctant to participate in more open activities communicating behavioral change.

HEALTHCARE SERVICES COMPONENT: SUPPORT AND TREATMENT FOR STIs AND HIV

The main purpose of this component is to create a structure that would offer MSM-friendly services and support for the treatment of STIs and AIDS by identifying a network of physicians and other providers who are sensitive to the needs of the target group and are able to provide medical and psychosocial services in a confidential and non-judgmental manner. Specifically, those services are as follows:

- Providing medical consultation to MSM that would include an in-depth medical history, a complete physical exam and all necessary laboratory tests;
- Providing individualized information and counseling sessions to each MSM client, and making available information on condom use and lubricants as well as booklets to take home;
- Treatment of STIs for MSM;

- Referral of HIV-positive patients for follow-up and treatment of opportunistic infections, and providing anti-retroviral therapy (ART) and psychosocial counseling at the Center for Ambulatory Care (CTA) where confidential medical records can be kept;
- Organize MSM support groups facilitated by a member of the medical staff and MSM peer educators.

ADVOCACY COMPONENT AIMED AT REACHING OUT TO SOCIAL PROFESSIONAL GROUPS THAT INTERACT WITH MSM

Actions Targeting the Media The partner agencies for these interventions have identified diverse media outlets committed to working together to change community attitudes towards MSM. These media groups invited resource persons and facilitators to collaborate in developing advocacy strategies to foster attitudinal changes in the population toward vulnerable persons and people at high risk for HIV/AIDS. A workshop has been organized for journalists and other media representatives in Senegal on the following topics:

- The overall HIV/AIDS issue in Senegal;
- The necessity to support persons at risk for HIV and the need for a program of psychological and medical care directed toward MSM in Senegal;
- Strategies for sustainable care for high risk groups given the context of the AIDS pandemic;
- Potential contribution of various groups in responding to HIV/AIDS in Senegal and in reducing the vulnerability of high-risk groups, such as prostitutes, PLWHA, orphans, MSM, and substance abusers.

Actions Targeting the Police and the Community-Based Organizations (CBOs) Exploratory research has elicited evidence of unsympathetic police and other law enforcement agencies' behavior towards MSM. The Senegalese NGO, Environment and Third World Development (ENDA), will initiate advocacy targeting law enforcement agencies in Dakar. It has identified police stations in the area where criminal and vice squads are willing to participate in an awareness campaign, and is planning the organization of workshops.

A police-specific training will help supervisors and managers to identify staff willing to participate in awareness sessions. In order to reach the largest number of policemen, a committee composed of NGO partners and MSM will be established to liaise with the police. In addition, CBO social workers will work in the community to reduce the stigma associated with MSM. Starting in the capital region, ENDA will identify CBOs with demonstrated experience in organizing a multi-sectoral response to HIV/AIDS, including providing care and assistance to vulnerable groups at risk for HIV infection and other STIs.

MONITORING AND EVALUATION OF INTERVENTIONS

Given the lack of data and the very limited experience in providing services and treatment for MSM, the interventions described above will need careful evaluation, as well as the identification of MSM categories—young, old, sexual workers, professionals, unemployed, head of household, etc.—to participate in activities and make newly available services accessible. The effects of these activities on MSM's knowledge, attitude and behavior over time also need to be evaluated.

All interventions will be documented systematically to highlight issues associated with the activities of different partner agencies. A descriptive analysis of successes, obstacles, and deficiencies will serve as a "road map" for other organizations which are trying to intro-

duce or improve services to MSM elsewhere. Researchers will assist each partner organization in documenting its internal processes and setting up monitoring systems. Data collected will be analyzed on a regular basis to determine the progress of the interventions and to propose corrective actions and adjustments, when necessary.

Also, the cost of service improvements and introduction of new services will be calculated, including such costs as staff salaries, equipment, transport and other inputs. This will assist decision makers and program managers in planning the scaling up of successful interventions and considering options for financing such interventions.

CURRENT STATUS OF IMPLEMENTATION OF THE PROGRAM IN SENEGAL

Implementing the various components of the program requires the involvement and the collaboration of many HIV/AIDS-related institutions in Senegal, under the coordination of the division of AIDS/STI within the Ministry of Health Hygiene and Prevention. The various partners in this process are: ACI, ANCS, CTA and OPALS (see the description below), the Institute of Social Hygiene (HIS), ENDA Health Program, the University Cheik Anta Diop of Senegal through its Institute of Science and the Environment, and the Population Council's Horizons Program. Each institution works in its own domain and links its initiatives to the activities of the others. The partner agencies meet and consult on a regular basis to exchange information on the progress of their activities, to monitor implementation, and to coordinate program activities.

AIDS/STI Division (CNLS/NSHP) The AIDS/STI division of the Ministry of Health along with the National anti-AIDS Council (CLNS) has been mandated with the overall coordination and administration of the various components and planned activities. It is also responsible for the dissemination and the uti-

lization of study results. The AIDS/STI division will coordinate the development of an advocacy program for the Ministry of Health staff and create a network of MSM-friendly providers.

African Consultant International (ACI) ACI plans to test a number of information and counseling strategies to reach MSM who are involved in risky behavior and who are not part of any network or association. These strategies will be implemented under the guise of general health and information services. ACI's services are intended for closeted MSM who are uncomfortable participating in services that target MSM overtly. Given its limited experience in care for this specific target group, for the first year, ACI proposes to pilot in Dakar a combination of measures and interventions. This period will be one of observation and identifying options, building capacity through training and support of peer educators or individuals through whom information on prevention and care can be channeled to closeted MSM networks. To that end, ACI will develop appropriate messages and materials to respond to the needs of MSM and it will evaluate the outcome at the end of the one-year pilot. This process will inform strategies targeting MSM and will lead to recommendations for the development of prevention and care activities in Senegal.

Strategies proposed by ACI include the following:

- Close collaboration with medical personnel, researchers and other persons who interact with MSM to identify those who have the potential and expressed interest in becoming peer educators within the MSM informal network;
- Development and field testing of appropriate messages and support materials based on specific MSM needs, which will

be identified progressively as the peer educators network grows;

- Identification of peer educators who would be able to reach the different MSM sub-groups in all social categories in Senegal, including those living with HIV;
- Establishment of a relationship of trust. Confidentiality and consent will be assured at all levels and MSM who are identified will receive information and training;
- Dissemination by MSM themselves of general information on HIV/AIDS prevention, on available services and service providers, as well as on relevant developments such as availability of condoms and lubricants, voluntary counseling and testing centers, and on additional sources of information or support for MSM;
- Overall coordination with the involvement of peer educators who are able to report and provide feedback to ACI through specially designed instruments;
- Documentation of overall intervention and their impacts in the MSM community in collaboration with the research partners.

The National Alliance Against AIDS (ANCS)

The Alliance's main goal is reducing the impact of HIV/AIDS among MSM. The ANCS seeks to strengthen its capacities for information and communication related to STIs, and HIV/AIDS, and specifically to better educate MSM and reduce their risky sexual behaviors and promote the use of condoms and lubricants. ANCS employs a three-pronged strategy to change behavior. First, ANCS builds MSM leaders' capacity through a training program on prevention, i.e. workshops with MSM leaders on counseling, treatment and support for

STIs and HIV/AIDS. Second, MSM are informed and educated in the use of communication tools, such as group discussion, videos, debates, and support groups. The third approach is making condoms and lubricants easily available to MSM.

ANCS will seek to strengthen capacity and support the development of MSM associations. It will also promote the formation of networks of MSM groups at the regional and international level. ANCS has experience in organizing workshops to train peer educators and companions or "buddies" in support services for PLWHA. The curriculum and training modules are well appreciated by Senegalese MSM. In addition to IEC programs, ANCS will implement a program of organizational and leadership development and good governance to build institutional and organizational capacity of MSM associations. ANCS will operate in the capital of Dakar and in large regional cities such as Thiès, Kaolack, Saint-Louis, etc.

Family Health International (FHI) FHI will handle two essential components of the program: (1) an advocacy program for healthcare personnel in order to create a network of providers that can care for MSM, and (2) provision of medical and psychosocial care for the target group in identified facilities. The advocacy and development of a healthcare personnel network aim at increasing the number of facilities with confidential services for MSM in order to limit their frequent trips to the rare MSM-friendly facilities in Dakar.

The medical and psychosocial care within identified facilities will consist foremost in fostering a climate of trust and confidentiality that will enable caregivers to counsel and treat MSM with a STIs or HIV. The program includes diagnosis and treatment of STIs, information and education, promotion of HIV testing, condom promotion and referral management.

A number of activities have been planned including:

- Development of appropriate communication tools that are easily accessible to MSM, including posters, brochures, flyers, etc.;
- Identification and training of personnel to provide targeted services to MSM;
- Upgraded clinics and laboratory equipment for diagnosis of STIs and HIV in facilities used by MSM;
- Delivery of education and information sessions on STIs and HIV for MSM during consultations.
- Assistance to the University Hospital at Fan and the CLNS division AIDS/STI in the overall care of persons with HIV;
- Community action through the participation of PLWHA in the operations of CTIN and revenue generating activities;
- Research in biomedical and social sciences.

A number of formal meetings are planned with providers in the network to share experiences on caring for vulnerable groups. The sessions are intended to better inform and to sensitize the providers—physicians, nurses, midwives, social workers, nursing aids, paramedics, and other medical personnel—about the program and to ensure their compliance with the principle of confidentiality.

Center for the Ambulatory Treatment (CTA) and the Pan African Organization to Combat AIDS (OPALS) CTA is a reference structure for PLWHA. CTA along with the Institute of Social Hygiene will be in charge of medical care, particularly ART, and of social care for MSM. Treatment and support activities by CTA essentially involve care for PLWHA through home-based care or outpatient clinics, the dispensing of medication for HIV and other pathologies such as tuberculosis and STI, and the integration of the patient in his community.

In the context of the program of OPALS, CTA's objectives are as follows:

- Training and information for medical and paramedical personnel and the development of training instruments;

OPALS is focused on the improvement of the quality of life of PLWHA in Africa by facilitating access to health services. The organization has expertise in counseling and the administration of ART. OPALS works in collaboration with national AIDS programs for medical and social follow-up of PLWHA and the development of community-based activities and the incorporation of research findings in the provision of services.

Environment and Third World Development (ENDA) ENDA focuses on advocacy, and targets social and professional groups that interact with MSM. Although ENDA's activities may seem negligible compared to the overall package of interventions, they constitute a crucial element of hope for MSM. ENDA demonstrates to MSM that efforts are underway to combat the abuse, stigma, and discrimination that are their daily lot because of their sexual orientation. Like ACI, ENDA is experienced in advocacy work as well as the development and the implementation of awareness campaign activities for vulnerable, marginalized, or HIV risk groups.

Population Council's Horizons Programs and University Cheik Anta Diop of Dakar The Horizons Program is tasked with documenting the entire process of interventions. Along with the Institute of Environmental Science of the University of Dakar, it will develop the protocol for the impact evaluation of the interventions. Horizons is a component of USAID's

efforts to reduce HIV transmission and to mitigate its impact on developing countries through operational research. The Horizons Program has been designed by the Population Council to identify policies that effectively combat HIV/AIDS and to pilot options for prevention, treatment, care and support services.

LIMITATION OF THE SENEGAL PROGRAM

The lack of political involvement is clearly a limitation of the program in Senegal. There has yet to be an official statement to support any action undertaken in favor of MSM or to combat stigma, violence and discrimination. This creates uncertainty for MSM and for the programs. Confronted with these social pressures, MSM live a secret life. A political commitment would energize the MSM community and guarantee program sustainability.

Program Proposed by the Office of Population Council in Burkina Faso

The Population Council's program for MSM in Burkina Faso has the following specific objectives:

- Design MSM-specific prevention messages for STIs and HIV/AIDS and ensure their effective dissemination in the MSM community;
- Improve public health services and organizations' delivery of services that are tailored to the needs of MSM;
- Achieve 80% of MSM to use non-discriminatory preventive and curative STI services provided by the public or private sector;
- Increase to 25% the identified MSM who seek to know their HIV status;
- Increase to 75% the use of condoms and lubricants in all MSM sexual acts;

- Create an environment to reduce various forms of stigma against MSM;
- Document the project's achievements.

The following strategies are proposed:

- Communication for behavior change to assist MSM in reducing the risk of STIs and HIV infection through sex or otherwise;
- Delivery of proper treatment, care and support services to MSM for HIV and STIs;
- Advocacy for a policy integrating MSM needs directed to administrators, health-care providers, media and other interested parties that interact with MSM.

This project should be directed by PA-PNLS. The following agencies should be included in the implementation of the project:

Ministry of Health The Ministry of Health, through its regional directorate in Ouagadougou and Bobo Dioulasso would be an important partner in the implementation of this project's activities. Major responsibilities include:

- Supervise project implementation;
- Facilitate project administration;
- Facilitate the identification of MSM-friendly facilities;
- Organize visits for steering committee monitoring;
- Supervise training activities.

Population Council The Population Council will be responsible for guiding, monitoring and documenting the activities. A permanent project team will be recruited and housed in the Population Council office in Ouagadougou. The Council is also responsible for the overall management and coordination between all

project stakeholders, the organization of operational research and guiding project strategies to achieve the expected results.

NGO/Partner Organizations A partnership will be established with NGOs, in particular the Association of African Solidarity and Vie Positive. Both NGOs have integrated HIV prevention and treatment activities for MSM in their operations for several years.

Private Community Initiative Against HIV (IPC/BF) IPC/BF is an NGO that focuses on supporting and strengthening community organizations engaged in fighting HIV in Burkina Faso. IPC has supported a number of organizations in designing innovative prevention and support programs for HIV/AIDS and STIs. IPC will be in charge of technical support for mobilizing and organizing groups and MSM meet-

ings to exchange experiences. It will design MSM-specific communication tools, inform and educate MSM on prevention of STIs and HIV/AIDS, and advocate with health workers and other agencies that interact with MSM.

Ambulatory Treatment Center (CTA) CTA is a treatment and testing center for STIs and HIV that cares for HIV positive MSM and those living with AIDS. Despite its program being favorably rated by Horizons, the organization has not received any financial or technical assistance to begin operations. The organization also focuses on research that would help assess the impact of planned interventions. An experienced sociologist from the Population Council in Ouagadougou will conduct the studies. These studies should precede the interventions for baseline data, but their realization seems doubtful because of time constraints.

Responses

Approaches and Strategic Pillars

Three complimentary intervention approaches can serve as the theoretical basis for designing strategies and activities. These approaches are as follows:

- Public health approach;
- Human rights approach;
- Culture-based approach.

Public Health Based Approach

The public health approach views HIV/AIDS as a problem or threat to the health of individuals or communities and focuses on the development of immediate responses to HIV/AIDS. It focuses on the sexual action; the public health approach does not distinguish among sexual orientations *per se*. Therefore, references to public health could be a mobilizing theme to legitimize or to trigger actions, speeches or interest in support of marginalized groups. In Senegal, networks and organizations that define men as their target populations can employ this approach, without distinguishing between sexual orientations. Those networks, even though they include a nucleus of MSM do not base their activities on sexual

identity. Rather, they fight all forms of discrimination based on sexual identity in a coalition bringing together the receptive *ibbi*, the penetrating *yoos* and bisexual and heterosexual men. The members of those networks and organizations are also involved in religious associations, which can also be mobilized in the fight against AIDS among MSM. Seeking alliances with religious figures in the public health context, and at the very least avoiding conflict with them, is an important strategy when targeting MSM. This was equally the case in the national strategy promoting condom use.

In the short term, the public health approach may be politically acceptable to partners and official agencies mandated to fight HIV/AIDS. This approach will also be more socially acceptable to the public sector, and to political and religious leaders. In Senegal, several MSM groups already carry out activities that are funded or supported by NGOs and the national anti-HIV program. In the Gambia and Burkina Faso, it should also be feasible to support activities initiated by similar groups.

Despite the effectiveness and acceptability of the public health approach, structural changes will not result if HIV/AIDS is viewed solely as a public health problem, when in fact effective

action requires political, economic, cultural and political interactions.

Human Rights Approach

While the public health approach may be a more effective approach for external managers of general programs, the human rights approach motivates those groups directly affected to fight for their rights. The human rights approach serves as the guiding principle to demand justice and equality. Its advantages are its universal language, its moral authority and its capacity to hold accountable the signatories of its international instruments in case of violation. In combating HIV/AIDS, the greatest advantage of the human rights approach is that it directly addresses political, social and cultural relationships and barriers to accessing prevention, treatment and care services by individuals or social groups. This approach effectively questions all forms of discrimination and violence by evoking human rights. In Senegal, the approach is well known and its concepts have been translated into the national languages used by the media.

As citizens, MSM are entitled to all the constitutional rights recognized by the State. Furthermore, they are accorded protection under any regional or international instrument signed and ratified by their State and recognized by United Nations' declarations and action plans. Most African countries have signed and ratified the international declarations that can serve as the basis upon which to mount advocacy in favor of MSM, including: the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment; the Convention on the Rights of the Child; the African Charter of Human Rights and Peoples' Rights. In addition,

other relevant rights for MSM are embodied in the declaration and action plans of conferences, such as: International Human Rights Vienna, 1993; the UN Conference on Population and Development, Cairo 1994; and The UN Conference on Women's Rights, Beijing 1995. In principle, all citizens, including MSM, have the same recognized rights, in particular: the right to life, the right to liberty, the right to security, the right to protection against violence and other mistreatments, and to physical integrity, the right to health, the right to education and work. Like any other citizen, MSM have the right to privacy, the right of assembly, the right of speech and all political rights.

Sexual and reproductive rights are inseparable from other rights, which are officially recognized by most states in the world. The 1995 Beijing conference action plan, adopted by Senegal and many other African countries, recognizes sexual rights, especially the right to sexual orientation as a fundamental component of reproductive health. However, without explicitly rejecting the notion, article number 319 in Senegal's penal code represses homosexuality, which is considered an immoral act against nature performed with an individual of the same sex. (Research Group on Women and Laws in Senegal, 2002). Legislation in other African countries displays the same paradox. Thus, the human rights approach has the limitation that it requires a very long process for its impact to be felt. At the same time, there are urgent needs that must be addressed immediately. Among the problems of the human rights based approach are the following:

- The State is all-powerful and may delay or not implement international legal instruments. Only the State has the power to sign and ratify international declarations and to take necessary measures to harmonize them with its own policies and programs. The State does not always demonstrate the political will to adhere to its international commitments.

- The rejection by society of the majority of sexual rights, in particular the right to sexual orientation, which is essential for homosexuals. In the name of cultural relativism, a significant number of Senegalese and African countries consider human rights to be foreign to their culture and religion. In Senegal, the predominant religious interpretations and practices are relatively conservative and thus constitute an important barrier to the implementation of any approach based on sexual rights. However, it is important to note that other theological interpretations exist in Senegal, and provide the argument that Islam is not hostile to human beings. Certainly, it will not be easy to achieve recognition and respect for the sexual rights of homosexuals.
- A third important obstacle to the human rights approach is civil society's lack of interest in defending sexual rights. Although civil society is well mobilized in the defense of economic and political rights, it demonstrates little interest in sexual rights. In addition, civil society includes a large number of homophobes.
- Finally, few MSM identifying openly as homosexuals organize themselves to defend their civic rights and their right to their chosen sexual orientation.

The human rights approach on many levels is appropriate for those organizations and West African networks that identify with the sexual orientation *gay* or *ibbi*.

The Cultural Approach

The cultural approach draws upon the local cultures to extract resources that permit responses to which the target population can identify because of an emotional historical continuity. This approach is necessary to for-

mulate interventions that are founded on socio-cultural institutions and rites associated with sexuality and sickness. The cultural approach also has an advantage in that it can mobilize groups and communities that identify with a given culture. The approach is based on the fact that even a homophobic society is never totally homogenous in its thinking. A socio-anthropological analysis of culture and communication can reveal elements for reinterpreting the heritage that can be used to mobilize MSM. In Senegal, the cultural approach could be adopted by several networks that are presented below.

Boy Town and Boy Médina Network. These are groups based in the neighborhood of Médina, Gueule Tapée, and Plateau in Dakar. They are essentially MSM with penetrating sexual identity, *yooos*, and a few with receptive *ibbi* orientation. Those networks identify with *gay* or *goor jigen* terms. They are composed primarily of young teenagers 17 to 25 year old and view this age group as the target for their interventions.

Group Laobe MSM Networks. The *Laobe* ethnic group is recognized as being specialized in the erotic education of society. MSM occupy different roles in the traditional activities of this ethnic group, notably in relations with women. The reason for including representatives of this network is to reach both MSM and the women with whom they interact socially. The use of poems and songs in the awareness campaigns is consistent with artistic expressions that are normally employed at key moments in the lives of individuals or groups.

MSM in the traditional networks in charge of Ndeup rituals. *Laobe* society organizes rituals called *ndeup*, which serve as collective therapies against mental illness and ecological dysfunctions. MSM and transvestites are integrated in the networks and may be in charge of the organization of ceremonies. The idea for the MSM campaign is to communicate HIV/AIDS prevention messages at those occa-

sions. In order to do this, ritual leaders must first be trained.

MSM in the traditional networks of “simb” sessions. MSM and transvestites are often members of the networks in charge of the organization of traditional sessions of *simb*, (false lion games), in Dakar, Thiès and Mbour. This setting can be used to communicate prevention messages.

MSM in the traditional wrestling clubs. MSM with the receptive *ibbi* and penetrating *yooos* identities belong to traditional wrestlers clubs. These clubs can be recruited to mobilize MSM and to disseminate prevention messages.

The cultural approach may be limited by its specific nature based on the relationships between responses and cultural eras in which they are implemented. Furthermore, communities or individuals living within the same area may not identify with the same culture and may not be concerned or reached by the messages.

Summary of the Objectives and Strategic Axes

The objectives and strategies developed in Burkina Faso, the Gambia and Senegal are fairly similar. The objectives often mentioned include:

- Improve MSM access to prevention;
- Strengthen capacity for communication and social mobilization;
- Strengthen the capacity of access to screening tests, and treatment and care services for STIs, and HIV/AIDS;
- Integrate MSM in the design, implementation and evaluation of HIV/AIDS programs and projects;
- Improve the social and economic environment for MSM.

In all three countries strategies are proposed for the short, medium and long term.

Short Term Strategies

The short-term objectives are essentially to strengthen and to enhance MSM direct access to prevention, treatment and care services for STIs and HIV/AIDS. Prevention will be promoted through communication strategies emphasizing behavioral change, the production and dissemination of appropriate messages adapted for MSM and the promotion of condom use. The prevention strategy most frequently cited in other countries' work is increasing awareness of the modes of transmission and the means of preventing STIs and HIV/AIDS. Awareness can be achieved through (awareness) workshops, informal meetings, especially meetings among friends and particularly among those sharing the same sexual orientation, activities in locations frequented by MSM (visits to beaches, meeting areas, prisons etc.), distribution of materials, and dissemination of messages during cultural or special events. For example, August 15 is a major holiday for a great number of MSM in the city of Saint-Louis; MSM participate in sessions of “false lions”, traditional fighting and the *lébou* ritual ceremonies, traditional dances of *taneber*, dances of *laobé*, fashion shows and other recreational evening events that are specially reserved for them.

In all three countries, the promotion of condoms and lubricants will be emphasized by activities that reinforce the development of skills to negotiate condom use, and by distributing condoms in existing networks, as well as at select events and places frequented by MSM during special events.

The strengthening of communication and social mobilization will be achieved through capacity building workshops for leaders, peer educators and resource persons. Resource persons are those having a special social relationship with MSM. They are, for example, the “grande

Box 1. Objectives and main strategies for MSM HIV/AIDS programs in Senegal, the Gambia and Burkina Faso.

1. Improving MSM access to prevention
 - Awareness of STIs and HIV;
 - Design and production of appropriate messages for MSM;
 - Dissemination of messages through the appropriate communication channels;
 - Distribution of condoms through MSM social networks;
 - Capacity building for negotiation of condom use.
2. Strengthen capacity for communication and social mobilization
 - Training leaders in communication and social mobilization against HIV/AIDS
 - Peer education for communication and social mobilization against HIV/AIDS
 - Training resource people in communication and social mobilization against HIV/AIDS
3. Improve access to screening, treatment and care of STIs and HIV/AIDS
 - Strengthen capacities for counseling and psychosocial care of MSM leaders
 - Strengthen capacities of resource persons in counseling and psychosocial support
 - Organization of MSM volunteers to provide psychosocial support to MSM living with HIV/AIDS;
 - Improvement of awareness of testing, treatment and care services;
 - Advocacy for the integration of MSM-specific issues in the delivery of testing, treatment and care services.
4. Integration of MSM in the design, implementation and evaluation of programs and projects in the fight against HIV/AIDS
 - Improvement of MSM's knowledge about the structures responsible for the design, implementation and evaluation of HIV/AIDS programs;
 - Strengthen the capacity of MSM to design, implement and evaluate their HIV/AIDS projects;
 - Establish structures and mechanisms for MSM to participate in decision-making concerning the fight against AIDS.
5. Improvement of MSM's social and economic environment
 - Advocacy for public commitment against all forms of violence and sexist stigmatization;
 - Strengthen MSM capacity to create groups of economic interest and health insurance;
 - Strengthen MSM capacity to develop self-esteem;
 - Improve MSM capacity to work in coalition with civil society organizations and women's associations in the defense of human rights.

dames” of Senegal or *jeggu-ibbi*, or *meru-ibbi* in the Gambia or leaders of male associations and religious groups. Communication and mobilization will focus on identifying local situations that

create risk of HIV/AIDS infection, the modes of transmission and prevention of HIV and STIs, and the promotion of condom use and voluntary testing and counseling.

Because MSM fear that their sexual practices could be exposed and vilified during testing and screening for HIV/AIDS or during STI or HIV/AIDS treatment, participants in this study's planning workshops have raised the importance of informing leaders, various categories of MSM and people interacting with them of the existence of services with guaranteed confidentiality within the health care system. This information could be disseminated during workshops and could include visits to counseling and testing centers or care facilities. In this context, it is important to develop an advocacy program that recognizes the specific problems of interpersonal communication and respect for MSM in the VCT and care centers. Resource persons in the Gambia, *jeggu-ibbi* and *meru-ibbi*, have also expressed an interest and the need for training in counseling and support. They also insisted on the need to strengthen skills in psychological support offered by the "homes" (or refuge) that constitute their living spaces.

Volunteers recruited from the various MSM associations and trained in special workshops could also provide psychological support for MSM living with HIV or affected by STIs. The volunteers' work is essentially that of facilitating discussion groups in care facilities for PLWHA, and the organization of care for hospitalized MSM who have been abandoned by their families or who are victims of discrimination and stigma. Finally, they can also arrange home visits to MSM living with HIV or STIs. That strategy must be accompanied by an advocacy program for health facilities so that they are aware of the support and psychosocial assistance offered by the associated MSM groups.

Medium Term Strategies

The strategies to strengthen MSM access to prevention increase the importance of fully integrating MSM in the design, planning and implementation of national responses against

HIV/AIDS, particularly for strategic planning or community planning. To that end, a number of MSM networks and associations should establish contacts and organize meetings and advocacy workshops with national and international HIV/AIDS agencies. The MSM networks and associations should also develop databases of electronic resources and HIV/AIDS fora and meetings.

Some associations and networks have recommended creating health insurance schemes to improve MSM access to treatment and care for STIs and HIV/AIDS. These schemes would fill the gap between poverty, the precarious living conditions of a large number of MSM and the high cost of care. The creation of insurance schemes could be supported by training workshops and lessons learned from the experiences of women's organizations. Focus group discussions concluded that economic independence plays an important role in autonomy, empowerment, acquiring leadership and improving self esteem. Resources result in access to better quality care, prolonged and improved quality of life. Therefore, some MSM associations proposed creating groups with joint economic interest (GIE) or savings and credit unions inspired by the experience of women's organizations in Senegal, especially with regards to their fundraising experience.

Long Term Strategies

Long-term strategies would address the fight against all forms of violence and discrimination particularly those affecting certain categories of MSM, especially the receptive sexual identity. The strategic analysis developed in the workshops and discussion groups for this study emphasizes that in addition to stigmatization, certain categories of MSM are also discriminated against in ways that recall the victimization of women by the denial of their political, social, economic and sexual rights. To promote their rights, women implemented strategies and concepts aimed at increasing

their political, social and economic powers in the long term. Some of these strategies could be relevant and effective in the proposed action plans of this study.

Feminists have highlighted the link between the vulnerability of women to HIV infection, power relations between the sexes, and the masculine social construct based on violence and risk. These lessons can be learned, and alliances with women's organizations formed to deconstruct/reconstruct masculine and feminine perspectives.

Long-term strategies also require the formation of alliances with civil society at the national and local levels, particularly associations defending human rights. In Senegal, these include: RADDHO, DRADI, and Amnesty

Senegal. Other important organizations are women's associations working on HIV/AIDS, and Islamic groups which proclaim or theolog-ically justify the respect of human rights. Additionally, other major strategies include meeting legal and social assistance needs for MSM at high risk of HIV/AIDS or discriminated against when accessing treatment.

Advocacy is also an important long-term strategy. Officials at all levels must be sensitized to the existence of sexual relationships among men and to MSM's vulnerability to HIV/AIDS. In this context, it is important to support the process of recognizing as partners the groups, networks and associations of MSM, regardless of their sexual identities or behaviors.

General Recommendations

Overall

The implementation of the above suggested strategies and activities designed for MSM should strongly rely on the MSM groups, associations and networks themselves, such as the ones identified in Senegal, Burkina Faso and The Gambia.

The overall approach suggested for Senegal is holistic and involves the implementation of many programs at many levels. It combines the unique perspective of each of the three specific approaches—public health, human rights and cultural—while recognizing their inherent limitations. These approaches may coexist within one group. However, it may be more efficient to emphasize one approach, with the others assuming secondary roles.

It remains important to maintain the diversity of these groups and associations. Each must be recognized as an official actor and partner in all of their organizational forms. The process of obtaining official recognition must be supported by NGOs, women organizations, other individuals involved in human rights defense, and activists combating HIV/AIDS. The diversity of the organizations reflects the diversity of sexual identities and

subcultures, as well as vulnerable conditions and possible strategic approaches. On the basis of this diversity, coalitions can be built.

Option I: An *intervention combining the approaches of public health, human rights and culture* seems to be the most appropriate in the context of the complex identities that characterize sexual relationships between men in Senegal, Burkina Faso and the Gambia. Nevertheless, the combined approach could present implementation difficulties.

Option II: The *human rights only approach* has the advantage of setting in motion processes of change in the social, political and cultural structures that produce structural vulnerability factors to HIV/AIDS by MSM. The main drawback to this approach is that it may elicit a violent backlash from society, which may perceive the interventions as an assault on its foundation.

Option III: A *public health only approach* has the advantage of being focused on behavior widespread in all societies, which would be politically and socially acceptable. The weakness of this option is that it does not lead to structural changes.

Option IV: A mainly or *exclusively culture-based approach* could be instrumental in mobilizing society and fostering acceptance by the community. Its key disadvantage is that its activities are directed to a limited socio-demographic group defined by culture. A limited cultural approach may stigmatize that part of the population that does not feel included.

Implementation

In all three countries it is important to develop the organizational, administrative and financial management capacity of the identified groups, associations and networks. To that end, it is necessary to involve experienced NGOs that are already fighting against HIV/AIDS or have experience in capacity building.

Option I: To implement strategies in all three countries, State officials and NGOs must be included as major partners in interventions. They can play an important role in training a critical mass of leaders and activists to develop skills in techniques for awareness, advocacy, administration and financial management. However, the drawback of this strategy is that it is possibly burdensome to implement.

Option II: Relying directly on MSM organizations, associations and networks could present the advantage of rapid implementation. However, the drawback to this option is the issue of sustainability due to the weakness of human resource capacity in those MSM groups.

Specific Recommendations

Senegal

The NGOs, ANCS, and ENDA Third World are very experienced in working with MSM. They can provide the institutional framework to support the implementation of action plans within the networks. ANCS and ENDA have worked and developed training modules that are quite appropriate for MSM. They are in contact with institutions that can provide additional technical resources. For example:

- ACI could produce flyers and awareness materials and organize meetings for advocacy;
- CTA and the psychiatric unit of the University of Fan could handle the training in psychosocial support.

As for the traditional networks, it is important to continue the ethnographic and sociological studies to build mutual acceptance and trusting relationships with NGOs, such as ANCS and ENDA Third World.

Monitoring and evaluation of the plans of action should be undertaken by research organizations such as Population Council's

Horizons Program, which has already accumulated a vast body of knowledge in partnership with the University Cheik Anta Diop of Dakar. Survey instruments designed by the Horizons Program, within the framework of evaluating the interventions cited earlier, could serve as a valuable source to generate impact indicators. In any case, CNLS should be involved in the supervision, control and analysis of lessons learned during the implementation of this plan of action.

Burkina Faso

The Population Council has extensive experience in exploratory MSM research. They have also designed an operational research protocol, which, if funded, would allow for the collection of baseline data and later an impact analysis of the interventions. Population Council is well positioned to monitor the activities implemented by AAS Vie Positive and IPC. Those organizations are well suited to serve as vehicles to provide financial and institutional support for MSM activities. They could jointly manage the activities conducted in the MSM networks in which they are associated.

The Gambia

ENS has a long history of working with community-based associations and has given them autonomy to design and implement their activities. Several NGOs such as BAFROW, World View, CBO/RAID, *Santa Yala*, Support Society, *Nganiya Killy* Society, WIC international, Anderson Care, and Red Cross could provide technical and logistical support for MSM in the Gambia. NAS is also interested in training trips to Senegal and the sub-region to promote an exchange of experiences among MSM decision makers, program leaders and peer educators.

Conclusion

This MSM research has highlighted that the diversity of sexual identities and sub-cultures in all three countries create different situations of vulnerability and frequently a gap between sexual identity and behavior. For these reasons, a holistic approach is required when designing strategies to improve MSM access to HIV/AIDS prevention, treatment and care services, which takes into account the complexities and all dimensions of the issues.

The vulnerability of MSM to HIV/AIDS appears to be associated with:

- Violence and stigmatization;
- Exclusion from care for STIs;
- Low impact of HIV/AIDS preventive messages on MSM who do not feel at risk;
- The double fear of stigmatization for being MSM and HIV-infected limits and

discourages access to counseling and testing services;

- Exclusion of MSM from the design and implementation of HIV/AIDS programs;

MSM are almost completely absent from programs involved in the fight against HIV/AIDS in Sub-Saharan Africa. Senegal is one of the rare countries with a program for MSM. This program is currently in the pilot stage. The strategy for integrating MSM in the fight against HIV/AIDS in Senegal, the Gambia and Burkina Faso relies on an approach that combines public health, human rights and culture. These approaches are short-term strategies that seek to strengthen MSM's immediate access to HIV/AIDS prevention, treatment and care, and long-term strategies aimed at bringing about social, political and cultural changes, which breed the factors of vulnerability affecting MSM.

The study has shown that Senegal, the Gambia and Burkina Faso, which receive World Bank support through the Multi-Country AIDS Program (MAP), should dedicate a substantial portion of their IDA resources to combat HIV/AIDS among MSM. Targeting this underserved group will contribute significantly to reducing and hopefully reversing the ravages of the epidemic in these countries. It follows from this research that the majority of Sub-Saharan countries would most likely also benefit by integrating MSM in their fight against HIV/AIDS. Failure to recognize the fact that sexual activity does not overlap with sexual identity puts the effectiveness of every national HIV/AIDS program in danger.

Presentation of Action Plans by Country

MSM Action Plan for Senegal

Various MSM networks and resource persons are aware of the action plans. “Network A” is the first group with which we worked. It is essentially composed of receptive (*ibbi*) MSM, many of whom do not hide their sexual identity, even though some members are discreet. Within this network, one section promotes the idea of open action with the intention of change at the societal level. Another section prefers to limit actions to the fight against HIV/AIDS.

“Network B” is a second group of MSM with whom we have collaborated to develop the logical framework for interventions. Network B’s statutes define it as: “an association fighting against HIV/AIDS in men regardless of their sexual preference.” Network B is composed of mostly receptive *ibbi*. Some penetrating *yooos* are also members, as well as some bisexual and even heterosexual men. The general philosophy of Network B is that relationships among men are a private and personal matter requiring discretion (the traditional *suturu* concept). Network B has solid relationships within the religious community and has developed the idea of working with organizations, networks and groups with predominately male

membership, such as football clubs, male sections of religious associations, army, prisons, etc.

Beyond those two networks that are aiming to develop non-traditional structures and momentum, there are other networks that are based on traditional organizations. Generally considered informal by official structures, we have grouped all of them in traditional networks.

Problems Identified by the Networks

The development of action plans is based on discussions held by MSM, who by consensus identified the problems, and situations facing MSM as follows:

- Low risk awareness for HIV even though MSM are generally aware of the main modes of HIV transmission and means of prevention;
- Low levels of knowledge about STIs but also limited recourse to health structures in case of contracting an STI. One of the main factors limiting their recourse to health services is stigma or the fear of being stigmatized;

- Stigmatization is also one of the determining factors that discourage MSM access to screening centers, and to treatment and care services for HIV/AIDS.

Violence and poverty also increase the risk of HIV/AIDS infection and marginalization, or even exclusion from treatment and care facilities.

From these observations it appears that MSM of various networks and various sexual identities share common objectives. While most of the strategies are similar, some differences are associated with the networks specific characteristics or identities. Likewise, proposed activities and interventions cut across all networks and identities, although some that were proposed relate to specific networks.

General Objectives of the Senegal's Plans of Action for MSM

The main objectives expressed in the various workshops include:

- To incorporate MSM in HIV/AIDS programs;
- To increase MSM awareness about STIs and HIV;
- To promote general condom use by MSM;
- To enhance MSM access to treatment services for STIs and HIV/AIDS;
- To eliminate violence and stigmatization against MSM.

These objectives led the various networks to slightly different strategies and action plans.

A. STRATEGIES AND ACTIVITIES PROPOSED BY NETWORK A

Strategies

- Advocacy towards agencies, programs and projects fighting HIV/AIDS;
- Training of leaders and MSM peer educators to increase awareness levels and psychosocial care for HIV/AIDS and STIs;
- Increase MSM awareness of the different HIV transmission modes and the means of prevention;
- Development of appropriate prevention messages and promotion of voluntary testing within the MSM community;
- Improvement of the availability of condoms in the networks closely associated with MSM;
- Increase awareness of discrimination against MSM in STI and HIV/AIDS care facilities;
- Advocate for NGOs and human rights organizations.

Activities

- One meeting to sensitize decision makers;
- One session to distribute flyers;
- Four training (or retraining) workshops of MSM leaders and peer educators (twelve to fifteen peer educators per training session);
- Four workshops on the modes of HIV transmission, the means of prevention and voluntary testing;
- Twelve discussion sessions followed by a movie screening;
- Two workshops to design and produce MSM-specific messages;
- Sessions to distribute flyers during MSM meetings;
- Four sessions of condom and lubricant distribution during MSM gatherings;

- Four meetings of awareness to sensitize healthcare workers (physicians, nurses, social workers) on MSM related issues;
- Two awareness sessions for NGOs and human rights organizations.

B. STRATEGIES AND ACTIVITIES PROPOSED BY NETWORK B

Strategies

- Training of MSM leaders and peer educators in awareness and in psychosocial care for STIs and HIV/AIDS;
- Sensitization of MSM networks on the modes of transmission and the means of prevention of HIV/AIDS and STIs, as well as voluntary testing;
- Awareness campaigns within prisons on the modes of transmission and the means of prevention of HIV/AIDS and STIs, and voluntary testing;
- Awareness campaigns for the male sections of religious associations on the modes of transmission and the means of prevention of HIV/AIDS and STIs, and voluntary testing;
- Awareness campaign within neighborhood sports and cultural organizations on the modes of transmission and the means of prevention of HIV/AIDS and STIs, and voluntary testing;
- Development of appropriate MSM prevention messages;
- Building negotiation skills for condom use among MSM;
- Capacity building to care for HIV and STIs among MSM;
- Capacity building to create health insurance schemes, GIEs and credit unions for MSM.

Activities

- Four workshops for MSM leaders and peer educators;

- Four awareness workshops on the modes of transmission and the means of prevention and voluntary testing;
- Twelve “tea-debate” sessions and distribution of flyers at residences where MSM gather;
- Four discussion sessions followed by distribution of flyers and condoms in prisons;
- Four discussion sessions and movie screenings followed by distribution of flyers in the men’s divisions of religious associations;
- Four discussion and movie screenings and competitive games with ASC in neighborhoods;
- Two workshops to design and produce appropriate messages for MSM;
- Four workshops to build negotiating skills for condom use;
- One-hundred visits to MSM living with HIV/AIDS at home or in hospitals;
- Four training workshops on support for PLWHA including MSM;
- Four training sessions on the creation of health insurance schemes, GIEs and credit unions.

C. STRATEGIES AND ACTIVITIES PROPOSED BY TRADITIONAL NETWORKS

Strategies

- Training of leaders of traditional networks and MSM networks with penetrating identities;
- Development of appropriate prevention messages and promotion of voluntary testing for MSM;
- Dissemination of prevention messages and promotion of testing during traditional activities and ceremonies.

Activities

- One training workshop for leaders of networks of MSM with penetrating identities, *Boy Town* and *Boy Médina*;
- One training session for leaders of the ethnic group *Laobé*;
- One training workshop for leaders of traditional networks in charge of the rituals of *ndeup*;
- One training workshop for leaders of traditional networks of *simb*;
- One training workshop for leaders of traditional fighters clubs;
- One workshop to produce messages of prevention and promotion of testing by the “club stars”;
- One competition with *simb* songs containing prevention messages and promoting testing;
- One gala with *ndeup* songs containing prevention messages and promoting testing;
- One session to produce traditional poems also called *taasu laobé* and songs with the themes of HIV prevention and promotion of testing;
- One workshop to produce appropriate messages of prevention, and promotion of testing within the networks of penetrating *Boy Town* and *Boy Médina*;
- One training workshop to produce prevention messages and promotion of testing by the stars of traditional fighting clubs;
- One workshop to produce songs of *simb* with messages of prevention and promotion of testing;
- One workshop to produce songs of *ndeup* with messages of prevention and promotion of testing;
- One workshop to produce traditional poems and songs with themes of HIV prevention and promotion of testing;
- One workshop to produce appropriate messages of prevention and promotion of testing within penetrating sexual identity networks of *Boy Town* and *Boy Médina*.

Table 1.A: Logical Framework Network "A" Senegal

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Include MSM in programs and projects designed to fight HIV/AIDS	Advocacy towards structures, projects and programs designed to fight HIV/AIDS	<ul style="list-style-type: none"> - (1) awareness meeting with decision makers - (1) Session to distribute flyers 	MSM are better inserted in programs and projects designed to fight HIV/AIDS	<ul style="list-style-type: none"> - Number of meetings - Number of flyers distributed - Number of programs and projects designed for MSM 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys
Improve knowledge of STI and HIV/AIDS by MSM	Training of MSM leaders and peer-educators for an awareness and psychosocial care of HIV/AIDS and STI	<ul style="list-style-type: none"> - (4) training workshops of MSM leaders and peer-educators (12–15 peers educators per training) 	MSM leaders and peer-educators able to lead awareness and care activities for HIV/AIDS and STI	<ul style="list-style-type: none"> - Number of workshops - Number of trained leaders peer-educators 	Activities Reports
	Awareness of modes of transmission, means of prevention, testing services by MSM	<ul style="list-style-type: none"> - (4) awareness workshops of transmission modes, means of prevention, voluntary testing services - (12) sessions of tea-debates with film projection 	<ul style="list-style-type: none"> - MSM better informed of modes of transmission and means of prevention of HIV/AIDS - Increased number of MSM accessing HIV/AIDS and STI care services - Increased number of MSM accessing voluntary services 	<ul style="list-style-type: none"> - Numbers of awareness workshops - Number of MSM participating in workshops - % MSM knowledgeable of modes of transmission and means of prevention of HIV/AIDS - % MSM who have submitted to a CTS - % MSM accessing HIV/AIDS and STI care services 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys
	Design of prevention and CTS messages for MSM	<ul style="list-style-type: none"> - (2) workshops to design and produce MSM-specific prevention and CTS messages - Sessions of distribution of flyers during meetings of MSM 	MSM receive appropriate messages	<ul style="list-style-type: none"> - Number materials produced - % MSM reached by appropriate messages 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys

Table 1A (continued)

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Strengthen condom use by MSM	Improve availability of condoms in close MSM networks	- (4) Sessions of distribution of condoms during MSM meetings	Increased number of MSM using condoms systematically	- Number of condoms distributed - % MSM using condom for each sexual contact - % MSM using condom during last sexual contact	- Activities Reports - Questionnaire surveys
Improve access to HIV/AIDS and STI care services by MSM	Awareness of discriminations against MSM by HIV/AIDS and STI care community	- (4) awareness meetings for health care workers (physicians, nurses, social workers) on MSM-specific issues	Reduced discrimination against MSM accessing STI and HIV/AIDS care	- % MSM accessing HIV/AIDS and STI care services	- Activities Reports - Questionnaire surveys
Eliminate stigmatization and violence against MSM	Advocacy towards human rights defense organizations	- (2) awareness workshops for NGOs and human rights organizations	Human rights NGOs and associations are aware of violence and stigmatization against MSM	Number of initiatives and commitments by human rights NGOs and associations	Activities reports

Table 1.B: Logical Framework Network “B”

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Improve knowledge of HIV/AIDS and STI by MSM	Training MSM leaders and peer-educators on awareness and psychosocial care of HIV/AIDS and STI	- (4) training workshops for MSM leaders and peer-educators	MSM leaders and peer-educators able to lead awareness activities	- Number of workshops - Number of trained leaders peer-educators	- Activities Report - Questionnaire surveys
	Raise awareness of MSM networks on modes of transmission, means of prevention and voluntary CTS of HIV/AIDS-STI	- (4) workshops on awareness of modes of transmission, means of prevention and voluntary CTS of HIV/AIDS-STI - (12) sessions tea-debates and home distribution of flyers to MSM	- MSM more knowledgeable of modes transmission, means of prevention and voluntary CTS of HIV/AIDS-STI - Increased number of MSM accessing HIV/AIDS and STI care services - Increased number of MSM accessing voluntary CTS	- Numbers of awareness workshops - Number of MSM participating in workshops - % MSM knowledgeable of modes of transmission and means of prevention of HIV/AIDS - % MSM who have submitted to a CTS - % MSM accessing HIV/AIDS and STI care services	- Activities Reports - Questionnaire surveys
	Raise awareness of prisons on modes of transmission, means of prevention and voluntary CTS of HIV/AIDS-STI	- (4) discussion sessions with distribution of flyers and condoms in prisons			
	Raise awareness of men’s sections of religious associations on modes of transmission, means of prevention and voluntary CTS of HIV/AIDS-STI	- (4) discussion sessions with distribution of flyers and condoms in men’s sections of religious associations			

Table 1.B (continued)

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
	Raise awareness of sports and cultural associations on modes of transmission, means of prevention and voluntary CTS of HIV/AIDS-STI	- (4) discussion sessions with film projections and games with sport and cultural associations			
	Design MSM-specific prevention messages	- (2) workshops to design MSM-specific prevention messages	MSM reached by appropriate messages	- Number of materials produced - % MSM reached by appropriate messages	
Generalize the systematic use of condom	Strengthen negotiating skills for condom use	- (4) workshops to strengthen negotiating skills for condom use	Increased number of MSM using condoms systematically	- % MSM using condom with each sexual contact	- Activities Reports - Questionnaire surveys
Improve access to HIV/AIDS prevention, testing and care services	Strengthen care capacity for HIV/AIDS and STI by MSM	- (100) home and hospital visits to MSM living with HIV - (4) training workshops in support care for PWHA	Reduced stigmatization and discrimination against MSM within the health care system	- Number of home and hospital visits to MSM living with HIV - Number of MSM trained in support services	- Activities Reports - Questionnaire surveys
Improve social coverage of MSM in case of sickness	Strengthen capacity for creation of health mutual insurance schemes, GIE, and credit unions among MSM	- (4) training workshops for creating health insurance schemes, GIE and credit unions	MSM able to create GIE, health insurance schemes and credit unions	Number of GIE, health and credit unions	- Activities reports

Table 1.C: Logical Framework Traditional Networks in Senegal

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Strengthen MSM capacities care of STI and HIV/AIDS	Training of leaders of traditional networks "penetrating" identity networks	- (1) training workshop of leaders of networks "penetrating" identity Boy-Town-Boy Médina - (1) training workshop of ethnic group Lobe leaders - (1) training workshop of leaders of traditional networks in charge of "Neap" ritual ceremonies - (1) training workshop of leaders of traditional networks of "Simb" sessions - (1) training workshop of leaders of traditional fight stables	Leaders able to organize communication and social mobilization activities to prevent HIV/AIDS	- Number of workshops - Number trained leaders	- Activities Reports - Questionnaire surveys
Improve knowledge of HIV/AIDS and STI by MSM	Design MSM-specific prevention and promotion of voluntary CTS messages	- (1) workshop of production prevention and CTS promotion messages by "Stars of stables" - (1) Gala with "Simb" songs carrying prevention and CTS promotion messages - (1) Gala with "Ndeup" songs carrying prevention and CTS promotion messages - (1) Session of traditional poems (Taasu Laobé) and songs carrying prevention and CTS promotion messages	MSM are reached by appropriate messages	- Number of materials produced - % MSM reached by appropriate messages	- Activities Reports - Questionnaire surveys

Table 1.C (continued)

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
		- (1) workshop of production of prevention and CTS promotion messages that are appropriate for "penetrating" identity Boy-Town-Boy Medina			
	Dissemination of prevention and promotion of voluntary CTS messages during traditional ceremonies	- (1) workshop of production of prevention and CTS promotion messages by stars of traditional fighting - (1) workshop to produce "Simb" songs carrying prevention and CTS promotion messages - (1) workshop to produce "Ndeup" songs carrying prevention and CTS promotion messages - (1) workshop to produce traditional poems (Taasu Laobé) carrying prevention and CTS promotion messages - (1) workshop of production of prevention and CTS promotion messages that are appropriate for "penetrating" identity Boy-Town-Boy Médina	Appropriate messages reach MSM	- Number of materials produced - % MSM reached by appropriate messages	- Activities Reports - Questionnaire surveys

Table 1.D: Budget Estimates for “Network A” in Senegal

<i>Cost Summary (CFA)</i>			
Activities	Unit Cost	Planned Number	Total Cost
Training workshop MSM leaders and peer-educators	560 000	4	2 240 000
Workshop to design and produce messages	1 353 000	2	2 706 000
Awareness workshop on modes of transmission, means of prevention and CTS	560 000	4	2 240 000
Training workshops in support care for PLWHA	560 000	4	2 240 000
Tea-debate	115 000	12	1 380 000
Training workshop on human rights	560 000	2	1 120 000
Advocacy meeting with decision makers	115 000	1	115 000
Training workshop on management and access to new training and communication technologies	560 000	4	2 240 000
Workshop on negotiating skills for condom use	560 000	4	2 240 000
Workshop of exchange with feminist organizations	560 000	2	1 120 000
Home and hospital visits to MSM living with HIV	10 000	100	1 000 000
Awareness galas with condom distribution during MSM ceremonies and meetings	300 000	4	1 200 000
Total			19 841 000

Table 1.E: Budget Estimates for the “Network B” in Senegal

Activities	Unit Cost	Planned Number	Total Cost
Training workshop MSM leaders and peer-educators	560 000	4	2 240 000
Workshop to design and produce messages	1 353 000	2	2 706 000
Training workshops in support care for PLWHA	560 000	4	2 240 000
Awareness workshop on modes of transmission, means of prevention and CTS	560 000	4	2 240 000
Workshop to strengthen negotiating skills for condom use	560 000	4	2 240 000
Tea-debate, neighborhoods	115 000	12	1 380 000
Discussions, distribution of flyers and condom in prisons	115 000	4	460 000
Discussions, film projection, distribution of flyers and condom in men’s sections of religious associations	115 000	4	460 000
Discussions, film projections games with sport and cultural associations	115 000	4	460 000
Home and hospital visits with MSM living HIV	10 000	100	1 000 000
Training workshops to create health insurance schemes, GIE and credit unions	560 000	2	1 120 000
Training workshop on management and access to new training and communication technologies	560 000	4	2 240 000
TOTAL			18 786 000

Table 1.F: Itemized budget for Networks A et B plans of action in Senegal (CFA)

<i>Cost of visits to patients</i>	
Category	Cost
Transportation fees	5 000
Purchase soap and meals	5 000
TOTAL	10 000
<i>Awareness session</i>	
Hall rental	25 000
Drinks	20 000
Rental projection equipment	50 000
Transportation fees facilitators	20 000
TOTAL	115 000
<i>Workshop Cost</i>	
Participants per diem	150 000
Honoraria for facilitators	80 000
Meals	180 000
Hall rental	75 000
Transportation and communication fees	75 000
TOTAL	560 000
<i>Workshop of design and production of messages</i>	
Participants per diem	150 000
Honoraria for facilitators	80 000
Meals	180 000
Hall Rental	75 000
Transportation and communication fees	75 000
Production of materials	1 000 000
TOTAL	1 560 000
<i>Organization of advocacy meetings</i>	
Communications fees	25 000
Transportation fees	75 000
TOTAL	100 000

MSM ACTION PLAN FOR BURKINA FASO

In Burkina Faso three networks of MSM have designed almost identical strategies and activities, which were derived from their identification of common problems and establishment of joint objectives.

Problems identified and related action plan is as follows:

- Few MSM feel at risk of HIV infections. This problem is linked to the fact that prevention messages do not target MSM but are exclusively directed towards heterosexuals;
- MSM have a low awareness of STIs transmission through sexual contacts between men;
- MSM have low negotiating power in the use of condoms and appropriate lubricants;
- Normal condoms are considered inappropriate for MSM;
- Lack of availability of quality condoms and lubricants, and the use of dangerous lubricants;
- Limited access to care and treatment for STI; cases of rejection and stigmatization in health facilities;
- Lack of access to care and treatment of HIV/AIDS, and lack of specific care for voluntary testing;
- Few MSM have recourse to voluntary testing for HIV/AIDS. Ignorance exists about voluntary counseling and testing for HIV/AIDS as well as available treatments.

Objectives

- Increased awareness levels of MSM about STIs and HIV/AIDS;
- Strengthened capacity of individual and collective MSM responses to HIV/AIDS;
- Increased use of condoms and lubricants among MSM;
- Improved access of MSM to treatment and care for STIs and HIV/AIDS.

STRATEGIES AND ACTIVITIES OF THE MSM NETWORKS IN BURKINA FASO

Broadly, the strategies proposed are the following:

- Train leaders and peer educators in awareness and psychosocial care of HIV/AIDS and STIs;
- Raise awareness among MSM about modes of transmission and means of prevention of HIV/AIDS and STIs as well as centers for voluntary testing;
- Organize MSM meetings to exchange experience;
- Promote the systematic use of condoms and make them available;
- Strengthen MSM negotiation skills to use condoms;
- Increase the awareness of care structures for STIs and AIDS about the various forms of stigmatization and discrimination against MSM.

Activities

- Six training sessions for MSM leaders and peer educators;
- Six training workshops on support;
- Six training workshops on awareness of the modes of transmission and means of prevention as well as the centers for voluntary testing;
- Four quarterly workshop per network of MSM, a total of twelve workshops for the three networks in Burkina Faso, which would reach 12 to 15 MSM per workshop;
- Twelve dinner debates;
- One dinner debate followed by the projection of films (one per network per quarter or a total of twelve dinner debates for the three networks, with the participation of 15 to 20 MSM per dinner debate);
- Distribution of condoms and lubricants during twenty meetings (awareness workshops, training workshops, dinner debates);
- Distribution of condoms and regular replenishment of condom supply (once per trimester) in each of the MSM networks;
- One workshop per network to strengthen capacities to negotiate the use of condoms;
- Two awareness workshops for healthcare workers, including public and private sector physicians and nurses, on specific MSM problems.

Table 2.A: Logical Framework for Burkina Faso

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Improve knowledge of HIV/AIDS and STI for MSM	Train MSM leaders and peers in awareness and psychosocial care for HIV/AIDS and STI	<ul style="list-style-type: none"> - Six (06) training workshops for MSM leaders and peers - Six (06) training workshops in support services 	<p>Leaders and peers are able to conduct HIV and STI awareness campaign</p>	<ul style="list-style-type: none"> - Number of workshops conducted - Number of leaders and peers trained 	<ul style="list-style-type: none"> - Activities Reports
	Raise awareness level of HIV/AIDS	<ul style="list-style-type: none"> - Six (06) awareness workshops on HIV/AIDS - STI transmission modes, prevention means and CTS by MSM 	<ul style="list-style-type: none"> - MSM more knowledgeable about HIV/AIDS-STI transmission modes; prevention means and CTS - Increased number of MSM utilizing HIV/AIDS-STI care services - Increased number of MSM utilizing CTS 	<ul style="list-style-type: none"> - Number of awareness workshops conducted - Number of MSM knowledgeable about HIV/AIDS-STI transmission modes, prevention means and CTS - % MSM knowledgeable about HIV/AIDS-STI transmission modes and prevention means— - Proportion of MSM submitting to CTS - % MSM utilizing STI care services - % MSM utilizing HIV/AIDS-care services 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys
Build individual and collective capacity of MSM to respond to HIV/AIDS	Organize meetings and exchanges between MSM	<ul style="list-style-type: none"> - (12) diner-debates - (1) diner debate followed by a film projection: 1 per network per trimester (Total 12 meetings) - 15-20 MSM per diner debate 	<p>MSM share experiences and knowledge of STI and HIV/AIDS</p>	<ul style="list-style-type: none"> - Number of diner - debates - Number of films shown - % MSM able to communicate about HIV/AIDS and STI 	<ul style="list-style-type: none"> - Activities Reports

Table 2.A (continued)

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Increase use of condoms and lubricants by MSM	<ul style="list-style-type: none"> - Promote systematic use of condoms - Make condoms available - Build negotiating skills for condom use by MSM 	<ul style="list-style-type: none"> - Distribution condom lubricants at 20 meetings (awareness workshops, training workshops, diner debates) - Regular stocking of condoms in each of 3 networks (1 per trimester) - (1) workshop strengthen negotiating skills for condom use 	Increased number of MSM utilizing condom systematically	<ul style="list-style-type: none"> - Number of condoms distributed - Number networks - Number of workshops - Number of trained MSM - % MSM using condom for each sexual act - % MSM who used condom during recent sexual acts - Number of unprotected sex contacts during the past month 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys
Improve access of MSM to HIV/AIDS treatment services	<ul style="list-style-type: none"> Raise awareness level of stigmatization and discrimination against MSM within the HIV/AIDS and STI care community 	<ul style="list-style-type: none"> -(2) awareness workshops for health care workers (public and private sectors physicians and nurses) on MSM-specific issues 	<ul style="list-style-type: none"> Reduced stigmatization and discrimination against MSM within the HIV/AIDS and STI care community 	<ul style="list-style-type: none"> - Number of workshops - Number of health care workers educated - Proportion of MSM who submitted to a screening test - % MSM utilizing STI care services - % MSM utilizing HIV/AIDS-care services 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys

Table 2.B: Budget Estimates for Burkina Faso

<i>Summary of Expenses (CFA)</i>			
Activities	Unit Cost	Planned Number	Total Cost
Training workshop peer educators	560 000	6	3 360 000
Workshop development and production of messages	1 060 000	2	2 120 000
Workshop awareness for MSM	560 000	6	3 360 000
Training workshop support	560 000	6	3 360 000
Dinner-debates	155 000	12	1 860 000
TOTAL			14 060 000

Table 2.C: Itemized Budget for Burkina Faso Action Plan (CFA)

<i>Expense per Workshop</i>	
Participants per diem	150 000
Honoraria for facilitators	80 000
Meals	180 000
Hall Rental	75 000
Transportation and Communication Fees	75 000
TOTAL	560 000
<i>Costs of organizing a message design and production workshop</i>	
Participants per diem	150 000
Honoraria for facilitators	80 000
Meals	180 000
Hall Rental	75 000
Transportation and Communication Fees	75 000
Production of materials	500 000
TOTAL	1 060 000
<i>Costs of Dinner with Debate</i>	
Hall Rental	25 000
Meals	60 000
Rental – Movie Projection	50 000
Transportation for Facilitators	20 000
TOTAL	155 000

MSM ACTION PLAN FOR THE GAMBIA

The problems raised by MSM while designing their plan of action include:

- Few MSM feel at risk of HIV infections. There lack of concern is tied to prevention messages, which do not specifically target MSM; they are exclusively targeted toward heterosexuals;
- MSM have a low awareness level transmission of STIs through sex relations among men;
- MSM have weak capacity to negotiate the use of proper condoms and lubricants. Normal condoms are inappropriate for MSM. Easy access to quality condoms and lubricants is lacking, and MSM use dangerous lubricants;
- MSM have poor access to care and treatment for STIs, and there have been cases of rejection and stigmatization in health-care structures;
- MSM have little access to care and treatment of HIV/AIDS, and specific treatment and care is lacking following voluntary testing and in case of HIV/AIDS;
- Few MSM have recourse to voluntary testing, or they are ignorant of voluntary testing, HIV/AIDS and its treatments.

We have worked with a group that united several MSM networks based on ethnicity and culture (a MSM network of Senegalese or Wolof origin, a network of Gambians, and networks of MSM from Liberia and Sierra Leone).

Objectives

- To integrate MSM in prevention messages and programs to fight HIV/AIDS;
- To promote the general and systematic use of condoms;
- To improve access to screening and treatment structures for STIs and HIV/AIDS.

Strategies and Activities Proposed in Gambia

Strategies

- Advocacy for agencies, programs and projects fighting against HIV/AIDS;
- Develop prevention messages adapted for MSM;
- Awareness training for MSM on modes of transmission and means of prevention of STIs and HIV/AIDS, and about the centers for voluntary testing;
- Improve access to quality condoms and lubricants;
- Improving MSM capacity to negotiate condom use;
- Strengthening companionship and psychosocial care of MSM;
- Strengthening the capacity of *homes* in prevention and the promotion of screening and care services.

Awareness can also be raised through cultural activities that serve to reunite large gathering of MSM groups. MSM generally gather for recreation called *tanneber*. These gatherings include several MSM networks as well as women with whom they maintain social relationships called *camen/jigeen*. Three or four such gatherings are scheduled per year. During those mass events, songs and games are used to disseminate messages on HIV/AIDS prevention and rejection of violence against MSM. These awareness campaigns will be supplemented with more restrained activities involving only MSM.

A dozen or so women called *jeggu-ibbi* or *meru-ibbi* have been identified as being longtime partners in the care and support of MSM. Training will extend their caring capacity by preparing them to provide psychological care and support to MSM and MSM living with HIV. These women's residences, called "homes," could be supported so that they can reinforce their capacity to become refuges for MSM, and also to support the role that these women currently play.

The same training could also be given to peer educators and MSM leaders.

Activities Proposed for Gambia

- Ethnographic, sociologic and epidemiological studies about MSM;
- Four workshops to disseminate research results;
- Two sessions of *tanneber* with the *jeggu-ibbi* or *meru-ibbi*;
- Sessions to distribute condoms and lubricants during twenty meetings (awareness workshops, training workshops, dinner debates);
- Supply condoms and replenish condom supply quarterly in each of the three networks;
- Workshop for each network to strengthen capacity to negotiate condom use;
- Four training sessions in counseling and support for *jeggu-ibbi* or *meru-ibbi*;
- One training session with peers on support and psychosocial assistance.

Table 3.A: Logical Framework for the Gambia

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Include MSM in HIV/AIDS prevention messages and control programs	Advocacy towards structures, programs and projects dedicated to fighting HIV/AIDS	<ul style="list-style-type: none"> - Ethnographic, sociological and epidemiological studies on MSM - Workshops to disseminate study results - (2) Training and exchange trips to Senegal and other countries in the sub region 	<ul style="list-style-type: none"> - Greater knowledge of the ethnography, sociology and epidemiology of MSM - Better integration of MSM in the programs and projects to fight HIV/AIDS 	<ul style="list-style-type: none"> - Number of studies conducted - Referral of MSM to official programs and projects - Number of workshops - Number of peer-educators trained - Number of MSM aware of workshops - Number of support services developed 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys
	Production of MSM appropriate prevention messages	<ul style="list-style-type: none"> - (3) workshops for design and production of conception and MSM appropriate prevention messages 	Awareness of HIV/AIDS and STI by MSM	Number of "tannaber"	Survey Reports
	Raise awareness level of HIV/AIDS-STI transmission modes; prevention means and CTS by MSM	<ul style="list-style-type: none"> - (4) workshops to train leaders and peer-educators - (4) awareness workshops for MSM - (2) sessions of "Tannaber" with "jegu-ibbi", "meru-ibbi" 	<ul style="list-style-type: none"> - MSM more knowledgeable about HIV/AIDS-STI transmission modes; prevention means and CTS - Increased number of MSM utilizing HIV/AIDS-STI care services - Increased number of MSM utilizing CTS 	<ul style="list-style-type: none"> - Number of awareness workshops conducted - Number of MSM knowledgeable about HIV/AIDS-STI transmission modes, prevention means and CTS - % MSM knowledgeable about HIV/AIDS-STI transmission modes and prevention means - Proportion of MSM submitting to CTS - % MSM utilizing STI care services - % MSM utilizing HIV/AIDS-care services 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys

(continued on next page)

Table 3.A (continued)

Objectives	Strategies	Activities	Expected results	Impact indicators	Outcome
Generalize the systematic use of condom	<ul style="list-style-type: none"> - Increase access to quality condoms and lubricants - Strengthen negotiating skills for use of condom 	<ul style="list-style-type: none"> - Distribution of condoms and lubricants at 20 meetings (awareness workshops, training workshops, diner-debates) - Regular supply (1 per trimester) of condoms in three networks - 1 workshop to strengthen negotiating skills for condom use per network 	<ul style="list-style-type: none"> - Increased number of MSM using condom systematically 	<ul style="list-style-type: none"> - Number of condoms distributed - Number networks - Number of workshops - Number of trained MSM - % MSM using condom for each sexual act - % MSM who used condom during recent sexual acts - Number of unprotected sex contacts during the past month 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys
Improve access to HIV/AIDS prevention, testing and care services	<ul style="list-style-type: none"> - Strengthen psycho-social support and care for MSM - Strengthen the capacity of "homes" for prevention and promotion of testing and treatment services 	<ul style="list-style-type: none"> - (4) training workshops for "jegu-ibbi"/"meru-ibbi" in counseling and support services - (1) training workshop for peers in psychosocial support 	<ul style="list-style-type: none"> - Trained "jegu-ibbi"/"meru-ibbi" MSM leaders prevention, counseling and support services - MSM accessing prevention and care services 	<ul style="list-style-type: none"> - Number of "jegu-ibbi"/"meru-ibbi", MSM leaders trained - % MSM utilizing HIV/AIDS-care services 	<ul style="list-style-type: none"> - Activities Reports - Questionnaire surveys

Table 3.B: Budget Estimates for Gambia

<i>Cost Summary (Dalassi)</i>			
Activities	Unit Cost	Planned Number	Total Cost
Training workshop for peer-educators	22 700	4	90 800
Training in counseling and testing			
Support services	22 700	4	90 800
Workshop to design and produce messages	62 700	3	188 100
Awareness campaign for MSM	22 700	4	90 800
Awareness/entertainment (Tanneber)	20 900	2	41 800
Trips to Senegal	78 000	2	156 000
Cost-awareness gala			
Sub-total (dalassi)			658 300
* Ethnographic, sociological, epidemiological studies			1 000
Total			659 300

Table 3.C: Itemized Budget for the Gambia's Plan of Action (Dalassi)

<i>Cost of workshop to develop and produce messages</i>				
Participant per diem				9 600
Honoraria for facilitators				3 600
Meals				3 000
Hall rental				1 500
Transportation and communication fees				5 000
Production material				40 000
TOTAL				62 700
<i>Workshop Cost</i>				
Participant per diem				9 600
Honoraria for facilitators				3 600
Meals				3 000
Hall rental				1 500
Transportation and communication fees				5 000
TOTAL				22 700
<i>Awareness and entertainment "Tanneber"</i>				
Meals				3 000
Chair rental				500
Hall rental				1 500
Payment to musicians				2 500
PA system rental				1 000
T- Shirt printing				3 500
Honoraria for facilitators				2 400
Camera rental				1 500
Transportation and communication fees				5 000
TOTAL				20 900
<i>Trips to Senegal for five days</i>				
Cost	Amount	MSM	Days	Cost
Round trip	800	10		8 000
Lodging and meals	1400	10	5	70 000
TOTAL				78 000

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