

**Exploring the Factors affecting
HIV Prevention Interventions
for Men who have Sex with Men (MSM)
in Cameroon:**

**A case study of Alternatives-Cameroun,
an NGO based in the city of Douala**

By Matthew John Kalamar

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Declaration

Submitted in partial fulfilment of the requirements for the degree of Master of Development Studies, in the Graduate Programme in the School of Development Studies, University of KwaZulu-Natal, Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master of Development Studies, in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

Student signature

Date

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Abstract

In the global HIV/AIDS pandemic, men who have sex with men (MSM) have experienced high levels of infection. Consequently, this population is considered a crucial target for prevention, care, and treatment efforts. In sub-Saharan Africa, however, most HIV transmission occurs via heterosexual intercourse, and 60% of HIV cases are women. African HIV epidemics are thus classified as “heterosexual” phenomena, and MSM are rarely targeted by public health programming.

Epidemiological studies now show that African MSM often have greater HIV prevalence than the general population. Behavioral research further indicates elevated sexual risk and low prevention-related knowledge levels among these men. Moreover, denial, stigmatization, and criminalization of male homosexual conduct across Africa have created social climates in which MSM remain “hidden,” fearing rejection or arrest. This has heightened their vulnerability to HIV infection. To counteract this trend, public health advocates call for prevention interventions adapted to the needs of African MSM. In a few countries, local NGOs have begun mobilizing around the “MSM issue.”

However, little information exists about HIV prevention among MSM in sub-Saharan Africa and the associations undertaking it. Using a case study of one such association – Alternatives-Cameroun – this project aimed to explore the factors affecting design and implementation of HIV prevention interventions for MSM in Cameroon.

Homosexual conduct is illegal in Cameroon, and MSM are frequently harassed and arrested. Nonetheless, Alternatives-Cameroun has launched prevention programming that reaches “hidden” MSM and addresses their unique characteristics. Through qualitative research involving stakeholder interviews and personal observation, this project found that local, national, and international factors all influence choices of intervention content and delivery formats. Interventions are designed by Cameroonian MSM, for Cameroonian MSM, but are also informed by empirical research and outreach principles drawn from other contexts. Implementation is a challenge in Cameroon’s hostile and resource-poor environment: stakeholders bear physical, emotional, and financial burdens during outreach. However, internal dynamics and foreign support help Alternatives-Cameroun mitigate these obstacles. This project reveals that understanding local realities and reinforcing multi-sectoral mobilization around MSM issues are important first steps towards launching HIV prevention interventions for MSM in sub-Saharan Africa.

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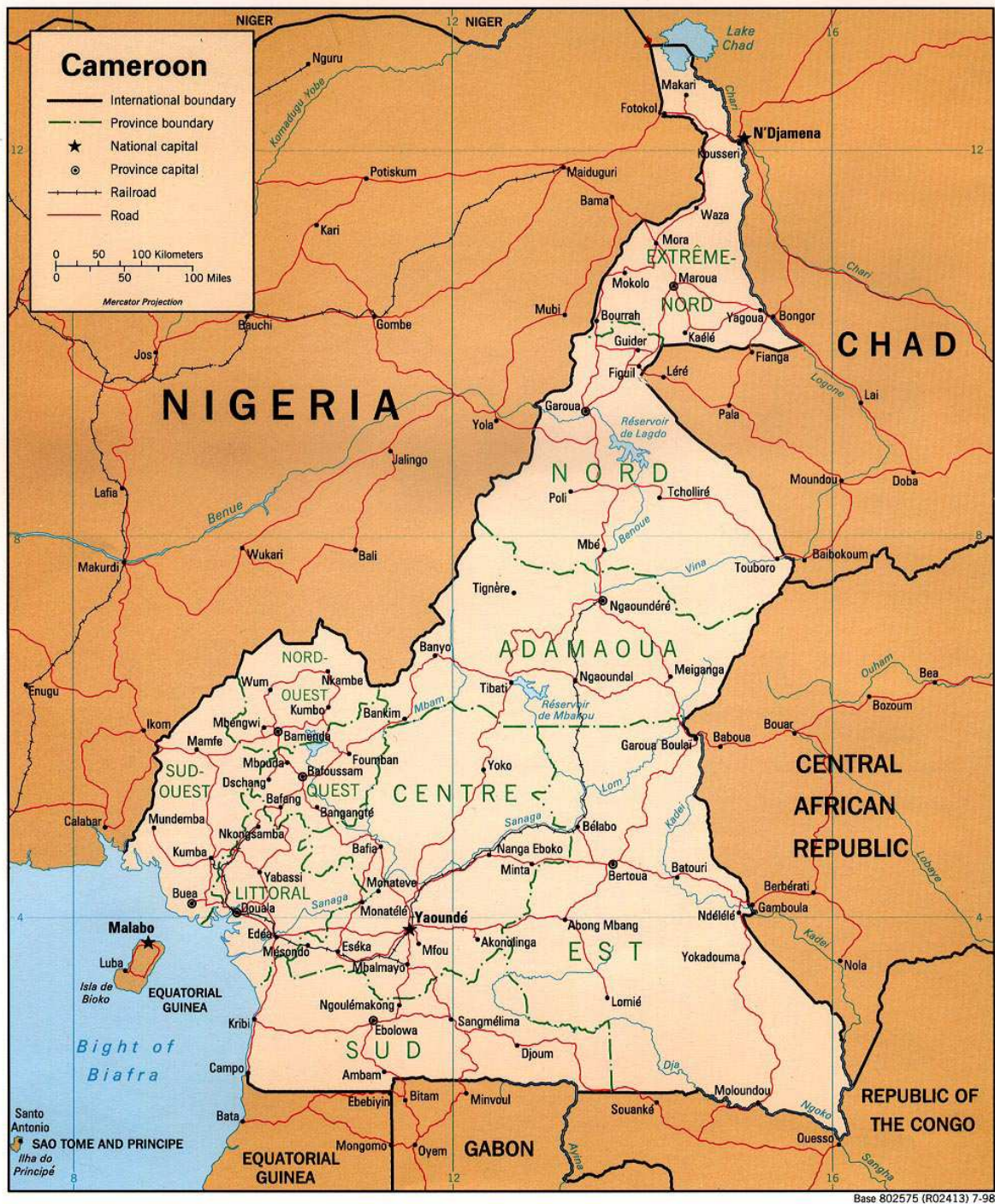
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Acronyms and Abbreviations

ABC	Abstain, Be faithful, use Condoms (prevention strategy)
AIDS	Acquired Immunodeficiency Syndrome
ARDHO	Association pour le Respect et les Droits des Homosexuels
ARV	Antiretroviral (medical treatment for HIV/AIDS)
BSS	Behavioral Surveillance Survey
CBO	Community-Based Organization
HIV	Human Immunodeficiency Virus
ICASA	International Conference on AIDS and STIs in Africa
IDU	Intravenous Drug Use
IGLHRC	International Gay and Lesbian Human Rights Commission
LGBT	Lesbian, Gay, Bisexual, and Transgender
MARP	Most At-Risk Population
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
PMTCT	Prevention of Mother-to-Child Transmission
SHPU	Sexual Health and Prevention Unit (at Alternatives-Cameroun)
STI/STD	Sexually Transmitted Infection/Disease
UAI	Unprotected Anal Intercourse
UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS	United Nations General Assembly Special Session of HIV and AIDS
VCT	Voluntary Counseling and Testing

Map of Cameroon



Source: Institute for Security Studies (2009)

Chapter 1: INTRODUCTION

The HIV/AIDS epidemic is a multidimensional challenge facing humanity, impacting not just on individual health, but also on the economic, political, social, and demographic well-being of societies. At present, 33.2 million people worldwide are infected with HIV (UNAIDS 2007), while the total number of people affected by the epidemic – families, children, friends, communities, and employers – is many times greater. The global response to the epidemic has been similarly multidimensional, as prevention and treatment interventions have reflected the conflicting values, perspectives, and resource constraints of societies. In Africa, a continent in a “state of [social] crisis” (Gueboguo & Mimche 2006, 14) as a result of decolonization, economic and political instability, and social unrest, the epidemic has hit particularly hard: 68% of all people living with HIV/AIDS and 76% of all AIDS deaths in 2007 occurred in sub-Saharan Africa (UNAIDS 2007).

The human immunodeficiency virus (HIV) can only be spread from human to human via infected bodily fluids, such as blood and semen. For anatomical reasons, men are more able than women to pass these fluids to their sexual partners (Panos Institute 1999). To be sure, the first cases of HIV, detected in the early 1980s in the United States, were almost exclusively among gay men, a pattern which has held in other “Northern” epidemics: in Western Europe, Canada, Australia and New Zealand (*ibid*). Another high-risk group for infection, especially in places like Russia, is intravenous drug-users, and the Panos Institute (1999, 129) estimates that “four times as many men as women inject drugs.” While it is believed that only one-in-four men engages in risky behavior, “[this] figure is high enough to maintain a localized or nationwide AIDS epidemic in almost every country” (*ibid*, 12). As such, behavior change among men has been at the heart of HIV/AIDS programming in the global North from the start (*ibid*).

In sub-Saharan Africa, however, most HIV transmission occurs via male-female sexual intercourse. With 61% of HIV cases among women (UNAIDS 2007), programming has been largely “heterocentric,” focusing on prevention of mother-to-child transmission (PMTCT), “abstain, be faithful, condomize” (ABC) strategies, and women’s empowerment. Homosexual transmission of HIV, in turn, has been largely ignored in Africa, or even outright denied. As Johnson (2007, 31) argues:

Early African male AIDS patients claimed they had never engaged in sex with other men, and the world was eager to believe them. The facile acceptance of these claims was a product of the racist belief in the hypersexuality – which could be understood as heteronormativity – of African men.

However, some African men do have sex with other men, and recent studies have shown that these men often have significantly higher HIV prevalence than the general population: 21.5% versus 0.2% in Dakar, Senegal (Wade *et al.* 2005); 40% or higher versus 6.1% in Nairobi, Kenya (Johnson 2007); and 18.42% versus 5.1% in Douala, Cameroon (Alternatives-Cameroun 2007). In the context of so-called “heterosexual epidemics,” men who have sex with men (MSM) appear to still bear the heaviest burden of infection and illness.

1.1 MSM: A Critical Gap in HIV Prevention in Africa

Despite a mounting epidemiological imperative, however, MSM remain stubbornly “off the map” of HIV/AIDS programming in sub-Saharan Africa (Johnson 2007). Across the continent, homosexual conduct is heavily stigmatized, often shrouded in secrecy, silence, and denial. As a result, most African MSM remain hidden, leading outwardly heterosexual lives with both male and female partners (Gueboguo & Mimche 2006). In contexts with high HIV prevalence, these men can thus function as a “bridge” between a high-risk group and the general population (Johnston *et al.* 2008). Homosexual conduct is also criminalized in 38 African countries, and African leaders have in recent years become increasingly virulent in their denunciations of homosexuality (*ibid*; see also Phillips 2004). This climate of fear and repression has only served to reinforce social marginalization and inhibit mobilization around the issue of HIV prevention for MSM. To date, most African countries do not explicitly target MSM in their national HIV/AIDS programming.

Johnson (2007) estimates that, at present, fewer than one-in-20 MSM worldwide has access to HIV prevention, care, and treatment services tailored to their particular vulnerability to infection – a situation especially problematic in places where MSM are most marginalized. Internationally, MSM are recognized as a high-risk group for transmission and infection. Activists and researchers alike advocate for the development of unique intervention approaches for MSM in the global South, incorporating culturally-specific strategies for reaching “hidden” MSM and changing their sexual behaviors, without putting them at risk for further marginalization. African civil society actors are beginning to mobilize around this

issue; Johnson (2007) cites a number of young community-based Lesbian-Gay-Bisexual-Transgender (LGBT) organizations across the continent.

Among these trailblazers, there is an understanding that programming for “MSM” must be substantively different from interventions targeting “gay” or “homosexual” men. Promoted by UNAIDS (2008b, 12), the phrase “men who have sex with men” and its abbreviation “MSM” are useful because “[they include] not only men who self identify as gay or homosexual and have sex only with other men but also bisexual men, and heterosexual men who may nonetheless at times have sex with other men.” In the global North, early responses to the HIV/AIDS epidemic largely came from gay communities themselves, and prevention messages reflected high levels of self-identification and mobilization within these networks. In sub-Saharan Africa, however, most men who practice homosexuality do so covertly – even if they personally identify as “gay” or “homosexual.”¹ Social and political pressures prevent the diffusion of same-sex-themed prevention messages and, furthermore, undermine the ability and willingness of individual MSM to speak openly about their sexual practices and identities. HIV prevention for these men must thus respond to their “hidden” nature, as well as to larger cultural, legal, and financial constraints on their behaviors.

For their part, local actors seeking to design and implement HIV prevention interventions for MSM in sub-Saharan Africa face a host of hurdles and dangers, from finding MSM and convincing them to participate, to developing adapted intervention techniques and securing the resources necessary for implementation. There is also the ever-present threat of violence and legal repression. Senegal, for instance, was the first African country to commission a prevalence study and commit national funds for interventions among MSM. It also hosted the 2008 International Conference on AIDS and STIs in Africa (ICASA) in Dakar, which focused heavily on MSM issues. And yet, barely three months later, nine Senegalese men, including several prominent local AIDS activists, were arrested and jailed on charges of homosexuality (Polgreen 2009). While the internationally-agreed principle is simple – MSM, as a high-risk group for HIV transmission and infection, must have access to adapted, context-specific prevention interventions – the reality in individual countries is complex and frequently hostile.

¹ For the purposes of this study, individuals will be referred to as “MSM” unless they self-identify otherwise; “homo/bisexual” will only be used to describe practices.

1.2 Aims and Objectives

Writing a decade ago, Parker, Khan & Aggleton (1998, 336) commented that “by far the most limited prevention efforts for [MSM] continue to characterize sub-Saharan Africa, where... the denial of same-sex behaviours has been most extensive on the part of researchers as well as governments.” To date, little has changed. Virtually all research on MSM and HIV/AIDS in sub-Saharan Africa has focused on prevalence and risk behaviors; the amount of prevention-focused research has remained low, reflecting the fact that little prevention work is occurring. To begin to fill this gap, this project has three objectives:

- To focus attention on homosexuality in sub-Saharan Africa;
- To highlight the position of MSM as a high-risk, vulnerable group within the context of Africa’s “heterosexual” HIV/AIDS epidemics; and
- To explore the factors affecting the design and implementation of HIV prevention interventions for MSM in one sub-Saharan African country: Cameroon.

The first two objectives are continental in breadth; while each country constitutes its own particular context – or contexts – the “MSM issue” is nonetheless seen as critical across Africa, with many studies showing shockingly high HIV prevalence levels among MSM regardless of general population prevalence (Wade *et al.* 2005; Johnson 2007). Research has also shown overarching patterns of silence, denial, stigmatization, and marginalization across the continent (Gueboguo & Mimche 2006; Panos Institute 1999). These first objectives, then, will help show that the “MSM issue” is not an isolated or niche problem, but rather a crucial gap in HIV prevention efforts across sub-Saharan Africa.

As prevention interventions remain local preoccupations, however, the second part of this study will focus on existing interventions in one country, organized around the following research questions:

- What HIV prevention interventions are currently being carried out among MSM?
- What has determined the content and delivery formats of these interventions?
- What factors have influenced their implementation?

These research questions will be addressed through a case study of one African NGO currently working on HIV prevention among MSM: Alternatives-Cameroun. Based in the city of Douala, this organization operates in a socially and legally hostile context, where

“homosexual conduct” is punishable with up to five years in prison.² Since 2005, this law has been enforced with increasing ferocity, leading to numerous cases of arrest, detention, and even torture (IPS 2009; IGLHRC 2006a; IGLHRC 2007). Using qualitative methods, this research will focus on the experiences, perspectives, and insights of the actors who have designed and implemented Alternatives-Cameroun’s HIV prevention interventions for MSM. This case study, embedded in the unique Cameroonian experience, will not provide generalizable information for sub-Saharan Africa. However, Alternatives-Cameroun is interesting for its quick ascent in stature and impact; at present, it is one of just a handful of African NGOs intervening openly among MSM. It is therefore hoped that this case study will provide indications as to how similar interventions can be designed and implemented elsewhere on the continent.

1.3 HIV Prevention Interventions: Design and Implementation

Within this study, “interventions” are defined generally as “techniques to improve communities’ health” (CDC 2007). “HIV prevention interventions,” then, seek to prevent HIV infection and transmission within a population, thereby improving its overall health. Murphy (2001, 1) observes that HIV transmission is affected by the “number of contacts between infected and uninfected” individuals and “the infectivity of the agent, or the risk of transmission per contact.” For an epidemic spread largely through sexual contact, prevention interventions should therefore aim to reduce both the frequency of serodiscordant sex³ and the possibility that HIV will be passed on during any single sexual encounter. In short, HIV prevention interventions must foster behavior change among both HIV-positive and HIV-negative individuals that will decrease opportunities for transmission.

Prevention research has concluded that “behavioral interventions provide an efficacious means of HIV prevention for MSM” (Herbst *et al.* 2005; see also Johnson *et al.* 2002; Elford and Hart 2003). That being said, these same studies challenge the notion that such interventions can be standardized for all MSM. Rather, Elford and Hart (2003, 301) conclude that “we need to formulate targeted interventions for groups with different needs and

² Homosexual conduct is criminalized under Article 347*bis* of the Cameroonian penal code. The original French text states: “*Est puni d’un emprisonnement de six mois à cinq ans et d’une amende de 20.000 à 200.000 francs toute personne qui a des rapports sexuels avec une personne de son sexe*” (cited in Ottosson 2007, 10), meaning “Any person who has sexual relations with a person of his/her sex will be sentenced to imprisonment of six months to five years and a fine of 20,000 to 200,000 francs” (approximately R450 to R4500).

³ “Serodiscordant sex” is defined as sex between an HIV-positive and an HIV-negative partner.

risk profiles.” This is no simple task. Social, political, and cultural contexts vary highly even within countries, and the strong impact of these contexts on sexual attitudes and behavior has been documented (Parker 2001; Rao Gupta 2000; Allen *et al.* 1992; Mane and Aggleton 2001; Campbell and Williams 2001). As such, interventions must be designed and implemented around the particularities of each target population, incorporating epidemiological data, behavioral surveillance, and contextual factors (amfAR 2006).

For this study, “design” is taken to mean the combination of substantive content (e.g., condom promotion, partner reduction, human rights, etc.) and delivery formats (e.g., targeting individuals, groups, etc.), while “implementation” describes the actual “lived experience” of diffusing these messages to MSM via these formats, within a given context. While research into these two processes is occurring in the global North, as well as in Latin America and Asia, no literature currently exists about how HIV prevention interventions for MSM are designed and implemented in sub-Saharan Africa. This is a critical gap: some prevention work is already taking place, and global civil society is calling for more, but very little data exists to guide adapting interventions for specific MSM populations. This case study of Alternatives-Cameroun’s HIV prevention interventions for MSM in Cameroon thus aims to provide insights into how these “techniques to improve communities’ health” are designed and implemented in data- and resource-poor settings.

1.4 MSM and HIV/AIDS in Cameroon: In the Lion’s Den

Cameroon, situated at the crossroads of West and Central Africa and home to the world-famous “Indomitable Lions” soccer team, is relatively developed by African standards. For MSM, however, life is precarious. Homosexual conduct has been criminalized in Cameroon since 1972, but aggressively enforced only since 2005. At the same time, however, Article 45 of the Cameroonian constitution stipulates that “international treaties or agreements which have been ratified [by Parliament] take precedence, as soon as they have been published, over the law” (UN 2000). As sodomy laws and discrimination based on sexual orientation are considered contrary to the African Charter on Human and Peoples’ Rights and the International Covenant on Civil and Political Rights – both signed and ratified by Cameroon – Article 347*bis* is thus widely considered illegal (IGLHRC 2006a; 2006b).

By many accounts, the “lived experience” of gays and lesbians in Cameroon has deteriorated markedly since 2005. In May of that year, the first of several high-profile mass

detentions occurred: 17 men were arrested at a nightclub in Yaoundé on presumption of homosexuality, eleven of whom were held for more than a year without trial, before nine were finally convicted – and subsequently released for time served – in June 2006 (IGLHRC 2006b). In October 2006, the United Nations Working Group on Arbitrary Detention ruled that the “Yaoundé 11” case violated Cameroon’s international obligations and requested the country to repeal its sodomy laws (IGLHRC 2007). However, arrests continued into 2007, with both gay men and lesbians imprisoned in Douala and Yaoundé, and Article 347*bis* remains in effect.

Social and cultural factors are seen as reinforcing homophobia and contributing to this recent repression. Homosexuality is widely denied and heavily stigmatized in Cameroon (Gueboguo and Mimche 2006). The country’s Minister of Justice has qualified it as un-African and “not a value accepted by Cameroonian society” (IGLHRC 2006a). Such views are reinforced by religious institutions, the media, and public authorities. The archbishop of Yaoundé, for instance, devoted his 2005 Christmas homily to a virulent denunciation of homosexuality. The media then capitalized on this by publishing several “Top 50” lists of suspected homosexuals in early 2006, accusing them of causing the economic and social decline of the country. One prominent Cameroonian human rights lawyer – the only one willing to defend suspected homosexuals – refers to these actions as a “witch hunt,” which only direct intervention by the national president was able to end (IPS 2009).

At present, LGBT Cameroonians live in constant fear of arrest and blackmail: despite Article 347*bis*’ requirement that an individual be found *in flagrante delicto* (“caught in the act”), all arrests have been based purely on suspicion or denunciation, and most have ended with convictions. Arrested men have thus endured imprisonment, torture, deteriorated health, and rejection by friends, family, and employers, all on mere hearsay (*ibid*). For instance, one of the “Yaoundé 11” died of AIDS-related complications shortly following his release, his poor health “exacerbated by the harsh conditions of detention” (IGLHRC 2006b).

To date, only one formal study has been conducted on MSM in Cameroon (Henry 2008). However, anecdotal evidence and other research suggests that significant MSM populations exist, and that HIV prevalence among MSM in Douala may be as high as 18.42% (Alternatives-Cameroun 2007) – more than three times greater than among the general population. Despite this epidemiological imperative, however, Cameroon has yet to incorporate MSM as a “vulnerable group” in its national responses; stakeholders in

Alternatives-Cameroun cited this as one of the reasons Cameroon's last three Global Fund applications were rejected. While these men are not, *a priori*, excluded from national HIV/AIDS programming, in practice disclosure of homosexual conduct leads to ridicule from doctors and runs the risk of exposing individuals to rejection and violence. As such, most homosexual behavior takes place in secret, and Cameroonian civil society has been overwhelming reluctant to enter the "lion's den" to engage the "MSM issue." At present, only one Cameroonian association openly intervenes among MSM to prevent and treat HIV/AIDS: Alternatives-Cameroun.

1.5 Organization of Dissertation

Chapter 1 introduced the HIV epidemic, its magnitude in Africa, and the reasons why male behavior is considered central to its spread. The position of MSM in this epidemic – and their virtual absence from HIV/AIDS programming in sub-Saharan Africa – was also presented. This chapter further enumerated the overarching aims and objectives of the study, provided the theoretical framework, and introduced the "lived experience" of MSM in Cameroon.

In Chapter 2, a comprehensive review of existing literature will be undertaken, covering homosexuality in Africa, the epidemiological position of MSM in sub-Saharan Africa's "heterosexual" HIV/AIDS epidemics, and the prevailing prevention strategies currently in place on the continent, both for MSM and the general population. This review will reveal the tremendous gaps in the literature and firmly justify the importance of this study.

Chapter 3 will describe this study's methodology, explaining the choice of a case study and the two selected research methods: stakeholder interviews and personal observation. The study setting and case study organization will also be presented in-depth, with a focus on Alternatives-Cameroun's history, context, and current HIV prevention activities. Finally, limitations and ethical issues related to this study will be discussed. The results and discussion arising from this study's fieldwork will then constitute Chapter 4. This section will highlight the overarching factors affecting the design and implementation of Alternatives-Cameroun's HIV prevention interventions for MSM in Douala.

Finally, Chapter 5 will provide a brief update of MSM-related news from sub-Saharan Africa since the beginning of the study, highlighting the many obstacles remaining for actors

seeking to launch HIV prevention interventions for MSM on the continent. Drawing on this study's major findings, recommendations will also be made for further action, both at Alternatives-Cameroun and across Africa, which could facilitate the design and implementation of HIV prevention interventions for MSM in sub-Saharan Africa.

Chapter 2: LITERATURE REVIEW

In order to begin exploring the factors affecting design and implementation of HIV prevention interventions for MSM in Cameroon, it is important to understand homosexuality in the Cameroonian and larger African contexts and the position which MSM occupy in Africa's so-called "heterosexual" HIV/AIDS epidemics. These areas are key, for they provide the rationale for targeting MSM in HIV/AIDS programming in Africa, while demonstrating the cultural, social, and legal constraints on such action. Attention will be paid to existing HIV prevention strategies – what works and what does not? – for both general populations and MSM in sub-Saharan Africa. By situating HIV prevention for MSM in Africa within the global context of HIV/AIDS programming, this literature review will set the stage for an examination of the factors affecting the design and implementation of Alternatives-Cameroun's HIV prevention intervention for MSM.

2.1 Homosexuality in Africa

Contrary to assertions by many African leaders that homosexuality is "a 'white man's disease' alien to 'African tradition'" (Phillips 2004, 158), both empirical and anecdotal evidence shows that homosexuality has always existed on the continent. Estimating the number of MSM in a society is difficult, and even more so in countries where homosexual conduct is outlawed and stigmatized. For HIV prevention, however, it is important to have a sense of how large the MSM population is, as well as how this population is perceived by society at-large. Only a small amount of literature exists specifically about homosexuality in Cameroon. On the other hand, the existing literature about homosexuality across Africa reveals certain trends and patterns observable in many contexts. As such, this literature review will be centered around Cameroon where possible, but also situate this country within the larger African context.

2.1.1 Existence of Homosexuality in Africa

In recent years, African political and religious leaders have become increasingly denunciatory of homosexuals and homosexuality, claiming like Ugandan President Yoweri Museveni that same-sex desire is "un-African" and declaring like Namibian President Sam Nujoma that "[t]he Republic of Namibia does not allow homosexuality or lesbianism. Police are ordered to arrest you, and deport and imprison you too" (Johnson 2007, 11; 13). Even

some researchers view homosexuality as “a new phenomenon [that] has... arrived through foreign influence” (Abega 1996, 6). Teunis (2001, 174) further claims that “[m]any western European anthropologists [agree that] homosexuality does not exist in Africa or caters to Western visitors only.”

Perhaps not surprisingly, no literature shows empirically that homosexuality was absent from Africa prior to colonialism, or that Africans became homosexuals through interactions with whites. In contrast, authors who study African sexualities overwhelmingly agree that homosexual conduct and relationships have always been part of African societies, may have been more socially accepted prior to colonialism, and are becoming increasingly visible due to globalization and HIV/AIDS. Phillips (2004, 161) contends that “[t]o claim that colonial settlers brought... new sexual activities to the region would be to insult the erotic imagination of southern African people,” and that the arrival of European colonists served only to redefine existing sexual acts (see also Parker, Khan & Aggleton 1998, 341). In pre-colonial Africa, he argues, sexual relationships were only considered problematic if they upset the reproductive and socio-economic functions of the heterosexual family. To that end, Johnson (2007, 12) suggests that “state-inspired homophobia... is an enduring legacy of European colonialism, not same-sex behavior” (see also Teunis 2001, 174).

Estimating *how many* same-sex practicing individuals exist in Africa is, however, much more difficult than establishing their existence. In their meta-analysis of research conducted on adult male sexual behavior in developing countries, Cáceres *et al.* (2006, iii4) found that only 67 of 561 studies estimated the prevalence of male homosexual activity, defined as “ever sex with another man,” “ever anal sex with another man,” and “sex with another man last year.” Of these 67 studies, only one concerned sub-Saharan Africa, making it the only region as of 2006 in which “male-to-male sex prevalence, lifetime” could not be estimated (*ibid*, iii5). An update of their analysis in 2008 revealed a figure for “ever sex with a man” of 1-4% of the general male population, although this hypothesis is based on just two studies, one each in South Africa and Kenya (Cáceres *et al.* 2008). At present, no data exists on prevalence of male homosexual activity in Cameroon.

Lifetime MSM prevalence around the world varies widely: 3-5% for East Asia, 6-12% for South/Southeast Asia, 6-15% for Eastern Europe, and 6-20% for Latin America (Cáceres *et al.* 2006, iii3). What these figures show, at least, is that homosexual activity does occur in every region of the world, among non-negligible portions of the male population. A very

recent study in Kampala revealed that “gay and bisexual men in Uganda are willing to identify themselves and participate in research” (Kajubi *et al.* 2008, 492), indicating potential openings for new research into male homosexuality in Africa. Moreover, study participants estimated that as many as 1000 other *self-identified* gay or bisexual men currently live in Kampala, hinting that, at least in cities, the *total* MSM population could be quite large.

That being said, there is little indication that researchers are willing to ask the general male population in Africa, or that this population would willingly answer, questions about the prevalence of male homosexual behavior. In Cameroon, for instance, Gueboguo and Mimche (2006, 22) quote one interviewee as responding, “[Homosexuality] is purely and simply a ‘white thing.’ Do not talk to use about things which do not exist in our country.” Johnson (2007) also notes that behavioral surveillance surveys (BSS) across Africa regularly omit questions about homosexuality.

2.1.2 Conceptions of Homosexuality in Cameroon and across Africa

While it is currently impossible to estimate the number of MSM in Cameroon, some academic literature does exist which confirms their existence and provides insights into how homosexuality is viewed in Cameroon and across Africa. A much larger body of periodic literature, from newspapers, magazines, and the Internet, constitutes a crucial portal for information about perceptions of homosexuality in Africa.

Gueboguo and Mimche (2006, 2) argue that homosexuality, a “sexual behavior in great turmoil” in Africa, is viewed in Cameroon as a choice that goes against cultural norms, religious morals, and human nature. The authors contend that homosexual Cameroonians are in fact following a larger national trend of sexual liberation since the 1970s, with increased premarital, transactional, and “visible” homosexual sex, and many choosing to “live differently” and “go against” traditional relationship models (*ibid*, 2; see also Abega 1996; URD 2006). Phillips (2004), like Gueboguo and Mimche (2006), sees the politicization of this trend – as well as legal and social resistance to it – as starting in earnest in the 1990s, with the ANC’s rise to power in South Africa and the subsequent decriminalization of homosexual conduct, banning of discrimination based on sexual orientation, and legalization of gay marriage. Johnson (2007, 16) similarly cites the 1994 decision by the United Nations Council on Human Rights that “the right to be free from discrimination based on sex [includes]... sexual orientation” as indicating the growing international recognition of sexuality as a human

right. Despite these developments, Cameroon and other African countries have remained “fundamentally homophobic and heterosexist,” with homosexual activity consistently viewed as a “cultural import” from the West (Gueboguo and Mimche 2006, 2; 13; see also URD 2006).

A complete account of homosexuality and its many manifestations across Africa is beyond the scope of this project. Instead, the following sections will present the larger themes into which perceptions of homosexuality in Cameroon can broadly be grouped. Information and anecdotes from other countries and sources will be incorporated to illustrate how Cameroon reflects the larger African context.

The Heterosexual Paradigm

In the popular imagination in Cameroon and across Africa, homosexuality is strongly associated with femininity, weakness, and lack of virility. While no specific terms appear to exist in Cameroon, Gueboguo and Mimche (2006, 5) cite others used in Africa to make this point: Senegalese MSM are called *gor jigeen*, or “man-woman;” the Swahili term *mke-si mume* translates as “woman and not man;” and in Hausa culture they are called *dan daudu*, or “man who acts like woman.” Hausa MSM of northern Nigeria are further known as “cross-dressers [who] have sex with men and frequently engage in activities specifically associated with women, yet are nevertheless often married to women and have children” (Teunis 2001, 178). Homosexuality is thus viewed as a reversal of traditional gender roles and a betrayal of men’s “genetic patrimony” (Gueboguo and Mimche 2006, 4). These authors argue further that, in Cameroonian society, this role reversal is often blamed on parents believed to have failed in properly socializing their child. On the other hand, in some countries this stereotype appears to unite the “hidden” male homosexual population: MSM discussion group participants in Togo, for instance, cited feminine hairdos and gestures, jewelry, and extravagant clothing as signs to help gays recognize and meet each other (URD 2006).

The “heterosexual paradigm” is pervasive in Africa. Gueboguo and Mimche (2006, 3) describe the “functional specialization” which African individuals are attributed by virtue of their biological sex. In this paradigm, only reproductive heterosexual intercourse is considered to be “real” sex – homosexual intercourse, in contrast, is seen only as “mutual masturbation” (*ibid*, 5). Phillips (2004, 162-3) contends that many African societies perceive “the establishment of a sexuality independent of lineage and guardianship [as disturbing] both inter-family and intra-family relations, as well as the highly structured nature of broader

gender relations” – and therefore the very foundations of these societies. In this worldview, he contends, non-reproductive sex is essentially an oxymoron, since lineage and family sit at the heart of all sexual relationships.

Significantly, the literature reveals that this “heterosexual paradigm” also structures homosexual relationships in Africa. In Togo, for instance, it was observed that MSM identified either as *hommes* (men) or *femmes* (women), depending on their sexual position: insertive or receptive, respectively (URD 2006, 14). These fixed roles complicate matters in so-called “versatile” relationships, in which the question must be asked: “who is the man, who is the woman?” (*ibid*) Teunis (2001, 177) describes similar dynamics in Senegal, with *oubis* (meaning “open,” i.e., receptive) and *yauss* (meaning “bad women,” i.e., insertive) maintaining functionally female and male identities, respectively, in terms of dress, gestures, sexual expectations, and even personal pronouns.

Social Order and Stability

Gueboguo and Mimche (2006, 19) argue further that in Cameroon homosexuality is considered a pathology, a state of mental deficiency, a perversion, and a deviance which contribute to “social malfunctioning and chaos.” In Togo, one neighborhood known to house homosexuals was even dubbed *Magna Magna*, meaning “chaos” (URD 2006, 10). This sentiment has been echoed across the continent. One Zimbabwean MP went as far as declaring:

The whole body is far more important than any single dispensable part. When your finger starts festering and becomes a danger to the body you cut it off. The moment you come to the conclusion that you cannot cure the finger you cut it off. The purpose of cutting it off is to preserve the body. The homosexuals are the festering finger endangering the body and we chop them off. (cited in Phillips 2004, 157)

President Robert Mugabe has also stated that homosexuals “[behave] worse than pigs and dogs” and rip apart the moral fabric of Zimbabwean society (*ibid*). Johnson (2007) points out that social and community cohesion is highly valued in Africa, and Mhone (2004, 315) contends that the concept of a “mutual-aid society” in which individualism is discouraged is the cornerstone of “traditional African society.” Phillips (2004, 159) argues further that anti-homosexual politicians in Africa have “sexualized” citizenship, such that heterosexuality,

understood as the only “natural” sexuality, has become a perceived condition for national belonging and social stability.

Morality

Religion is frequently used to justify more aggressive attitudes towards homosexuality in Africa. In Cameroon, where the Catholic Church is particularly strong, homosexuality is widely considered a sin (Gueboguo and Mimche 2006). As mentioned earlier, it was the archbishop of Yaoundé who instigated the outbreak of homophobia in Cameroon in 2006 (Olinga 2006; Gueboguo [pending]). Johnson (2007, 97) agrees and cites Emmanuel Kamau, an LGBT activist in Kenya: “We hear frequent stories of gay and transgender people [being] turned away from HIV services, particularly those managed by religious people who find LGBT lifestyles... immoral.” In Togo, the obligation to get married and reproduce is justified not just on social grounds, but also as “one of God’s commandments” (URD 2006, 10).

Olinga (2006) perceives the role of religion as more than just moralizing: it is an active attempt to compete more effectively with the “massive arrival” of American evangelical churches. One local commentator observed a rise in religious fundamentalism, whose adherents “have decided to deliver justice vicariously. They identify evil and they fight it. Homosexuality is a part of that evil” (cited in *ibid*). Catholic NGOs, furthermore, appear to have supported the publishing of the “Top 50” lists, so that “each person will be able to avoid the paths of depravity” (Spokesman of the *Service œcuménique pour la paix*⁴, cited in *ibid*).

Speaking more broadly, Phillips (2004) argues that homophobia in its present form was brought to Africa by Christianity. He writes that “sexual values and definitions were irrevocably altered” by “proselytizing settlers” who, emboldened by Christian morality, recategorized homosexual conduct as an “unnatural offense” (*ibid*, 161; 162). In pre-colonial Africa, he concludes, “the neat and definitive binary division of homo/heterosexual [was] not so clearly replicated in reality as it [was] in ideology” (*ibid*, 162). To be sure, a quick glance at African laws criminalizing homosexuality reveal the legacy of Europe’s “Christian” colonization of Africa: these laws punish “acts against the order of nature” in Angola, “attacks on good values” in the Democratic Republic of the Congo, “unnatural carnal offenses” in Eritrea, and “indecent acts” in Ethiopia (Ottosson 2003).

⁴ Ecumenical Agency for Peace

Socio-Economic Mobility

Homosexuality in Cameroon is further viewed as a “practice of upper classes” and “a ladder for social ascent, an instrument of power and domination,” whereby the nation’s elite get rich “by the sweat on their brows or the sweat on their asses” (Gueboguo and Mimche 2006, 6; Bimogo 2006). The archbishop of Yaoundé stoked this perception in his Christmas homily: “they are trying to impose homosexuality on the youth as an itinerary for success, or as a condition for admission to certain state exams” (quoted in Zinga 2006). The “Top 50” lists are further seen as “a symptom of a society tired of having its hopes dashed, of unkept promises, and of being held hostage to the common good of a (wealthy) minority” of homosexuals (Bimogo 2006). Beyond Cameroon, Gueboguo and Mimche (2006, 15) cite a perspective held among the Pangwé people of western equatorial Africa that homosexuality is a “medicine for wealth.” Parker, Khan & Aggleton (1998, 330) cite research concluding that sex between men is “linked to the achievement of rank or social status” in Kenya and other countries in East Africa. Finally, in Togo, the notion of “opportunistic homosexuality” has been noted, whereby same-sex conduct is considered a strategy for earning money or acquiring goods, especially from tourists” (URD 2006, 12). Homosexuality is thus widely viewed as a practice perpetuated by economic need and social ambition.

Homosexuality in Cameroon is further associated with sects and “esoteric networks,” such as the Freemasons, believed to be the sole means of entering the “social elite” in a context of deepening poverty, increasing unemployment, and a widening income gap (Olinga 2006; see also Gueboguo and Mimche 2006). Another conception views homosexuality as “occult activity” (Macauley 2009) and its practitioners as “sorcerers” (Gueboguo and Mimche 2006, 7). All of these conceptions view homosexuality as functionally devious, a means of reserving power for a minority at the expense of the majority. Interestingly, however, Johnson (2007, 19) notes that “the experience of most LGBT Africans is one of economic impoverishment and disenfranchisement.” This may, for one, explain the high levels of transactional sex observed among MSM, to be elaborated on later.

Rights of Passage and other Social Functions

Finally, homosexuality has been recognized as part of certain “rights of passage” in some African countries. In Togo, for instance, researchers heard anecdotes of traditional priests and chiefs who, while living away from their wives in a “convent” to prepare for their

future roles, would “engage in masturbation in order to relax themselves, by finding a means of bringing about ejaculation” (quote from an elderly interviewee, cited in URD 2006, 9). Homosexual conduct in such cases is believed to confer certain powers upon the practitioner or “[test] and [verify] the efficiency of certain charms/talismans” (*ibid*, 10). In Togolese culture, then, homosexuality may be tolerated socially as long as it serves an “initiatory or sacrificial” function (*ibid*).

Phillips (2004) sees such ideas as old concepts labeled with new language: in short, these activities were not considered “sexual” prior to the imposition of Christian morality and definitions of homo/heterosexuality (see also URD 2006, 11). He cites research conducted in the 1980s and 1990s in Lesotho on “lesbian-like behavior,” which manifested itself in “erotic and romantic relationships between women [which did] not require an individual’s autonomy from family, marriage, and kinship” (*ibid*, 161). As with the behavior exhibited in Togo, this practice did not seek to create a new form of sexual relationship equal to heterosexual marriage, as modern-day LGBT rights movements do (*ibid*, 157).

What is clear from this review of the literature on homosexuality in Cameroon and across Africa is that same-sex conduct and relationships are generally considered aberrant, unnatural, and problematic. As a result, African men and women who experience homosexual desires frequently live a “double life” – outwardly conforming to social expectations of marriage and family, while experiencing true sexual release and pleasure in secret (Gueboguo and Mimche 2006, 11). This juxtaposition of sexual liberation and social repression is especially troublesome in the era of HIV/AIDS, where individual behaviors have health-related consequences across communities and societies. The following section will examine this further, looking at MSM in the context of Africa’s “heterosexual” HIV/AIDS epidemics.

2.2 MSM and HIV

Anatomical and behavioral factors render MSM a “high-risk” group for HIV infection (UNAIDS 2006; amfAR 2006; Cáceres *et al.* 2008; Larmarange 2008; Broqua 2008a). In the developed world, but also in Latin America and Asia, homosexual transmission of HIV has been extensively researched and targeted in interventions (McFarland & Cáceres 2001; Johnson 2007). In Africa, however, fear and denial have compromised efforts to combat HIV among MSM (Phillips 2004; Johnson 2007). While the African epidemic is largely fueled by

heterosexual transmission via extensive sexual networking (Bongaarts 1996; HELLERINGER & KOHLER 2007), the first epidemiological study of MSM in sub-Saharan Africa, conducted in Senegal in 2004, showed shockingly high HIV prevalence compared to the general population: 21.5% versus 0.2% (Wade *et al.* 2005). It is hypothesized further that African MSM, prone to have both male and female partners, could serve as “a bridge for HIV transmission to their female partners and the general population” (Johnston *et al.* 2008). Taboos and restrictions on same-sex behavior may also increase rates of partner change and thus the chances of HIV transmission (Panos 1999). To begin thinking about HIV prevention interventions for MSM in sub-Saharan Africa, one must first investigate the position MSM occupy in the continent’s “heterosexual” HIV/AIDS epidemics.

2.2.1 Prevalence and Incidence

Prior to the groundbreaking Senegal study, no HIV prevalence data existed for MSM in sub-Saharan Africa, and to date, no incidence data exist. In contrast, MSM have been studied in almost all Latin American countries, showing HIV prevalence and incidence to be higher among MSM than any other social group – a trend also apparent in parts of Asia (Larmarange 2008, 61; see also Wilson 2008). Fortunately, the number of prevalence studies among MSM in Africa has increased rapidly since 2004, showing that, in almost all countries, MSM are significantly more likely to be HIV-positive than the general population.

It is estimated that African MSM are two-to-20 times more likely to be infected with HIV than the general population (Larmarange 2008). In Douala, Cameroon, a convenience sample of MSM revealed a prevalence of 18.42%, over three times higher than the national average (Alternatives-Cameroun 2007). In Kenya, prevalence is estimated at 43% for MSM claiming exclusively homosexual practices and 12.3% for bisexual MSM (Sanders *et al.* 2007). In another Kenyan study, 13% of exclusively homosexual MSM were HIV-positive, versus 9.6% of bisexuals and 7.3% of non-MSM, based on voluntary counseling and testing (VCT) data for nearly 89,000 men (Angala *et al.* 2006). To date, little published prevalence research exists. At the 2008 AIDS conference in Mexico City, however, a number of new studies were presented, concerning the following countries:

- Sudan: 9.3% for receptive, 7.8% for insertive MSM (Elrashied 2005; 2008)
- Malawi: 21% (Umar *et al.* 2008)
- Nigeria: 13.4% (Adebajo *et al.* 2008)

- South Africa: 13.9% (Sandfort *et al.* 2008a)⁵
- Zanzibar: 12.3% (Johnston *et al.* 2008)

This troubling data, drawn from every region of the continent, has greatly heightened the attention directed at the “MSM issue” by AIDS activists and policy-makers alike.

As prevalence data for MSM in sub-Saharan Africa accumulates, it is becoming easier to calculate the contribution of male-male sex to national HIV/AIDS epidemics. UNAIDS (2008a) estimates that 5 to 10% of all HIV infections worldwide can be attributed to male homosexual conduct. Van Griensven (2007, 1361), drawing on new epidemiological data from Senegal and Kenya and “tentatively [assuming] that male-male sex occurs in 3% of adult males,” puts this figure at 9.8% and 19.7%, respectively – decisively showing that MSM are in no way a negligible group in Africa’s “heterosexual” HIV/AIDS epidemics.

2.2.2 Behaviors and Risks Factors

Given that attention has only very recently been directed towards MSM in sub-Saharan Africa, little research has explored risk factors for HIV infection among this population. The literature which is available, however, paints a picture of high behavioral risk among African MSM. As mentioned earlier, the sexual practices of MSM place them at a higher risk for HIV transmission than heterosexual men, mainly due to the practice of anal sex. The Panos Institute (1999) puts the odds of male-to-female transmission via unprotected vaginal intercourse at one-in-500, compared to one-in-1000 for female-to-male transmission. For anal intercourse, however, it is estimated that the odds of transmission from receptive anal sex is between one-in-125 and one-in-31, while the odds for the insertive partner is roughly the same as for vaginal intercourse (Murphy 2001). It is thus clear that receptive anal intercourse – a common practice among MSM – is a high-risk activity for HIV transmission.

Prevalence of Unprotected Anal Intercourse

A few studies have demonstrated the high prevalence of unprotected anal intercourse (UAI) and minimal use of condoms among MSM in sub-Saharan Africa. In Senegal, Wade *et al.* (2005) found that, in the previous month, 24% of MSM had engaged in unprotected insertive anal intercourse with at least one male partner, while 20% had received anal

⁵ South Africa is a particular case, however, given its very high general population prevalence. This figure for MSM is in fact lower than national prevalence and based on self-reporting among the roughly 72% of the study’s sample that declared having ever been tested. It is therefore possible that this figure understates the reality among MSM.

intercourse without using protection. Kajubi *et al.* (2008) reported figures of 36% and 37%, respectively, in the last six months for self-identified gay and bisexual men in Kampala, Uganda. Johnston *et al.* (2008) found that 57.5% of MSM in Zanzibar had had more than two non-paying male insertive partners in the month preceding the study, while 70.2% had had more than two male receptive partners. Moreover, only 28.8% reported using condoms with their last male partner (insertive or receptive), indicating similarly high levels of UAI as in Senegal and Uganda.

In Sudan, only 8.8% of insertive MSM systematically used condoms, a figure which increased just to 27.6% for intercourse with *commercial* receptive partners (Elrashied 2008). Furthermore, in Douala, Cameroon, a study of MSM sexual practices showed that, in the prior six months, 68.6% had engaged in insertive and 52.9% had received anal sex (Henry 2008⁶). While 43.7% declared systematic condom use during anal intercourse, close to 30% admitted they “sometimes” or “never” use protection, indicating a persistent elevated risk of HIV transmission among MSM in Douala (*ibid*). Finally, a study in Zambia found that only 6% of MSM used a condom during their last anal intercourse, and – shockingly – less than 10% were aware that condoms could be used during anal sex (Zulu 2005).

In contrast with this data, however, a study conducted in Malawi, Botswana, and Namibia found that condom use was “quite common” – the research leader commented that “These guys help and support each other. Every time they travel abroad, they bring back KY jelly (a brand of water-based lubricant) and condoms” (Beyrer *et al.* 2009). In some places, at least, protective behaviors may be gaining traction in MSM communities. More studies are needed to determine what factors – cultural, geographic, socio-economic – reinforce condom use among MSM.

While most studies attest to the high frequency of UAI among MSM in Africa, the empirical association between this practice and HIV infection remains inconclusive in the literature on African MSM. The Zanzibar study found that, despite low levels of condom use, HIV infection was only associated with having had more than two *receptive* anal partners: “No association [was found] between HIV infection and number of non-paying male *insertive* partners” (Johnston *et al.* 2008). Somewhat paradoxically, “condom use at last male sex” was

⁶ Henry’s (2008) study of MSM in Douala represents the only existing literature about sexual risk factors among this population in Cameroon. It was conducted with the help of Alternatives-Cameroun; in fact, most of the stakeholders interviewed for this project were involved in data collection for Henry’s study. Since Alternatives-Cameroun is based in Douala, it can be assumed that Henry’s findings are generally representative of the association’s target beneficiary population.

also associated with HIV infection – a finding corroborated by a study in Kenya (Angala *et al.* 2006). For all of these findings, no thorough explanation was given; it is thus not clear if perhaps, for instance, MSM in Zanzibar and Kenya who use condoms do so because they know they are HIV-positive. In contrast, one study found that “not always using condoms” was statistically associated with seropositivity (Beyrer *et al.* 2009). Other studies investigating both UAI and HIV infection found no statistical association between them (Wade *et al.* 2005; Umar *et al.* 2008). While especially receptive anal sex is known to be a risk factor for HIV transmission, there is as yet little data statistically associating HIV infection and high frequency of UAI among MSM in sub-Saharan Africa.

Multiple Partners, Bisexual Practices, and Sexual Identity

Shelton *et al.* (2004, 891) state it plainly: “There would be no global AIDS pandemic were it not for multiple partnerships.” Significantly, many studies have found that MSM in sub-Saharan Africa are highly likely to have multiple sexual partners – of both sexes. As Larmarange (2008, 62) contends, “a majority of MSM also have sexual relations with women and [do not] identify themselves at all as ‘gay,’ ‘homosexual’ or ‘queer.’” Moreover, Wade *et al.* (2005) point out that bisexual behavior is common among MSM around the world, ranging from 23% in Fortaleza, Brazil (sex with a woman in the past year) to 79% in St. Petersburg, Russia. As Cairns (2009) observes, “the already-noted tendency in Africa to have long-term concurrent relationships with more than one partner... [is] the same for MSM, with a high proportion of men engaging in ‘bisexually concurrent’ relationships.”

In Cameroon, Henry (2008) found that MSM had an average of fifteen male and three female sexual partners in their lifetime. Additionally, nearly 50% had a current, stable female partner. Zanzibari MSM had an average of 5.7 male partners in the previous month, and 60% declared also having had at least one female partner (Johnston *et al.* 2008). Interestingly, this study found having had “any female partner in the past month” to be significantly associated with HIV infection. In Kajubi *et al.* (2008), which did not look at HIV infection, a full 39% self-identified as bisexual, and 46% of the total sample (self-identified gay and bisexual men) reported having had at least one female partner in the last five years. In Malawi, over 75% of MSM admitted to having many male partners – fourteen, on average – and for the 56% of MSM that also had female partners over the same period, the mean was twelve (Umar *et al.* 2008). Moreover, this study found that self-identifying as “homosexual” or “bisexual” was statistically correlated with HIV infection, a finding consistent with an earlier study in Kenya

(Sanders *et al.* 2007). Among Senegalese MSM, 94.1% reported ever having sex with a woman, and 60% reported having had more than three male partners during the previous twelve months, indicating high levels of bisexual activity (Wade *et al.* 2005). This study also found that having more than nine lifetime male partners was significantly associated with HIV infection. Finally, Elrashied (2005) concluded that 97.2% of receptive MSM in Khartoum, Sudan, had more than one sexual partner at any given time.

While none of these studies illustrate the dynamic connections between multiple partnerships, bisexual practices, and sexual identities, all demonstrate that MSM frequently pursue sexual relationships with both men and women, and as such can indeed serve as “bridges” for HIV transmission to the general population.

Drug Use

Drug use, and particularly intravenous drug use (IDU) – known to be fueling HIV epidemics in Russia and the former Soviet Union (Wilson 2008) – was cited in one study as “strongly associated with HIV infection,” with 14% of MSM in Zanzibar engaging in IDU (Holman *et al.* 2008). High levels of IDU were also observed among MSM in Botswana (3.4%), Namibia (8%), and Malawi (12%), although no statistical correlation with HIV infection was found (Beyrer *et al.* 2009). While no other studies in sub-Saharan Africa have explored this connection, it is nonetheless suspected that MSM engaging in IDU have “more unprotected anal intercourse, are more often infected with HIV and have less access to testing services” (Broqua 2008a, 64). Given the overwhelming connections found between IDU and HIV infection in Southeast Asia, for instance (Wilson 2008), this is an area that clearly needs more attention from researchers and policy-makers in sub-Saharan Africa.

Transactional and Forced Sex

Johnson (2007, 38) argues that “[e]conomic exchange plays a role in sex among men,” an assertion supported by the existing literature. Johnston *et al.* (2008) found that 65% of MSM in Zanzibar had received cash for sex at least once, a practice defined as an “unsafe risk behavior.” In Sudan, 80.3% of insertive MSM declared having ever paid their receptive partners (Elrashied 2008), and in Kenya, 41% of MSM “reported to be doing it for money” (Zulu 2005). In Douala, Cameroon, Henry (2008) found that one-third of MSM had engaged in some form of transactional sex during the previous six months and concluded that “financial dependence on one or more sexual partners, the exchange of money or gifts in an

amorous or sexual relationship or having had sexual relations with a male or female sex worker... was related to less systematic use of condoms.” One hypothesized reason for this phenomenon is that transactional sex – either commercial or friendly, between men and women or between two men – reduces the power which receptive, i.e., usually less powerful partners have to negotiate condom use and thereby increases their risk of HIV infection (Broqua 2008b; Henry 2008; see also Mane and Aggleton 2001).

Another risk factor to be considered is forced sex. Wade *et al.* (2005, 2136) found that 30% of MSM had “ever [been] physically forced to have sex with a man,” and that 10% had been forced during their first homosexual intercourse. Twenty-one respondents even claimed to have been raped by policemen. Although the correlation between forced sex and HIV infection was not statistically significant, this study nonetheless found prevalence of 31% for MSM who had at least one forced sexual encounter (*ibid*, 2138). Johnson (2007) cites the Horizons Project study, conducted in Nairobi, Kenya, as finding that nearly 50% of MSM had been raped at some point in their lives. In Cameroon, many of the men arrested in 2005 and 2006 were raped in prison; IRIN News (2006) quotes one former detainee: “As homosexuals, we were the first in line for sexual abuse of prisoners.” This trend has also been recognized and increasingly targeted by major international actors in the fight against HIV/AIDS (UNAIDS 2008a). As relatively little data on MSM and forced sex in sub-Saharan Africa exists, however, more research must be conducted on this issue.

Other Factors

Several other factors were found to be statistically associated with HIV infection among MSM in sub-Saharan Africa, including: older age (Wade *et al.* 2005; Sandfort *et al.* 2008a; Angala *et al.* 2006; Beyrer *et al.* 2009); younger age (Umar *et al.* 2008); profession as a waiter or bartender (Wade *et al.* 2005); living in Dakar (Wade *et al.* 2005); “reporting signs or symptoms of an STI in the past 6 months” (Johnston *et al.* 2008); condom use at last sex (Angala *et al.* 2006); and being married (Angala *et al.* 2006). New technologies may also be encouraging risk-taking: an “as yet unexplained” association has been found “between seeking sex on the Internet and increased risk behavior” (Elford and Hart 2003). All of these factors could have important implications for the design and implementation of HIV prevention interventions for MSM, and some, such as STI status, are known to increase the risk of infection (Johnson 2007). However, more research is needed to effectively integrate these findings in HIV/AIDS programming for MSM.

What emerges from a review of literature concerning MSM behaviors and risk factors in sub-Saharan Africa is that, at present, countless holes exist in our understanding of these populations. To fully appreciate the cultural, social, and even political influences on male homosexual behavior in Africa, and its subsequent impact on the continent's "heterosexual" HIV/AIDS epidemics, much more epidemiological and ethnographic research must be done.

2.2.3 Perceived Risk

MSM in sub-Saharan Africa often underestimate the risk of HIV transmission associated with their sexual practices. Much of this is due to misunderstandings of the virus and how it is transmitted. Georges Kanuma, head of the *Association pour le Respect et les Droits des Homosexuels* (ARDHO)⁷ in Burundi, claims that "[MSM have] a perception that HIV [is] a risk for men who sleep with women, not gay men" (PlusNews 2008; see also URD 2006; Cáceres *et al.* 2008). Zulu (2005), for instance, found that 73% of MSM in Zambia believed that anal sex was safer than vaginal intercourse. Moreover, of the 10% of MSM reporting STIs, almost all blamed their illness on women. In Sudan only 45% of receptive MSM knew of the connection between anal sex and HIV transmission (Elrashied 2005), and in Cameroon a majority of MSM are "sure that there [is] no risk of infection with anal penetration" (Alternatives-Cameroun, cited in IRIN News 2008). This perceived low risk for HIV infection has in at least one study, conducted in Uganda, been associated with higher prevalence of unprotected receptive anal sex (Kajubi *et al.* 2008). More troublingly, a study in Togo reported serious misconceptions about HIV transmission, with MSM claiming they can eliminate the risk of infection by using enough lubricant to prevent anal bleeding; defecating just after intercourse; and only having the insertive partner ejaculate, believing that the infection risk is higher if both partners ejaculate (URD 2006).

If MSM do not perceive their risk of infection as *lower* than for heterosexuals, there is evidence that MSM nonetheless view their risk as *equal*, with no particular vulnerability related to their sexual practices (Henry 2008; URD 2006). To explain this, several studies reported that MSM often have less knowledge about HIV/AIDS and STIs than the general population (Diop *et al.* 2008; Broqua 2008a) and also minimal access to VCT services (Broqua 2008a; Angala *et al.* 2006). Many MSM do not see their lives or practices reflected in national-level prevention campaigns, which are seen as addressing heterosexual men only

⁷ Association for the Respect and the Rights of Homosexuals

(Henry 2008; Phillips 2004). A more activist perspective sees “[t]he vulnerability of same-sex practicing men... [as] not due to any biological predisposition, but [as] the result of an interlocking set of human rights violations and social inequalities that heighten HIV risk” by denying MSM access to adapted prevention and care services (Johnson 2007, 2). All of these issues have strong implications for HIV prevention among MSM in sub-Saharan Africa and are dealt with a body of literature all their own, presented in the next section.

2.3 HIV Prevention for MSM: A Global Call to Action

Globally there is agreement that MSM are highly vulnerable to HIV transmission and should be targeted by prevention, care, and treatment interventions (UNAIDS 2006; amfAR 2006; FHI 2008; Johnson 2007; URD 2006). Additionally, such programming should be multi-sectoral, joining the forces of governments, civil society, and community-based and international NGOs to adapt interventions to the context-specific risk environments in which MSM live out their sexualities (*ibid*). At present, however, it is estimated that less than one-in-20 MSM worldwide has access to programming that responds to their unique needs (UNAIDS 2006; Johnson 2007). Even in countries where such interventions exist, UNAIDS (2008a) estimates that only 40% of MSM are effectively reached. Civil society, policy-makers, and academics around the world therefore argue for increased integration of MSM in national AIDS responses, including interventions that reach “hidden” MSM in developing countries and address sexual risk, personal protection, self-esteem, violence and homophobia, and skills development (UNAIDS 2006; FHI 2008; amfAR 2006).

To date, only a handful of countries in sub-Saharan Africa, including Kenya, Nigeria, Senegal, and Burundi, have answered this global call to action and incorporated MSM into their national HIV/AIDS programming (Johnson 2007; PlusNews 2008; see also Parker, Khan & Aggleton 1998). However, nowhere is the path clear of obstacles. Johnson (2007) notes Nigeria’s efforts to pass a “Same-Sex Prohibition Act” restricting the rights of LGBT individuals to meet and form associations. The recent high-profile arrests of MSM in Senegal also “threaten this progressive public health strategy” (*ibid*; see also Polgreen 2009). Some countries have even outright refused to discuss MSM: in Uganda, the Minister of Information threatened UNAIDS with expulsion if it set up educational interventions targeting MSM (Johnson 2007). Given the widespread criminalization and stigmatization of homosexual relations, it is clear that not just medical and behavioral, but also social, cultural, and political

factors must be addressed in HIV/AIDS programming for African MSM (Johnson 2007; UNAIDS 2006; amfAR 2006).

2.3.1 HIV Prevention: What works?

Research has provided important insights into which prevention strategies work – and which do not. Concerning Uganda, the African country with the most success in stemming a generalized HIV epidemic, there is overwhelming consensus that “reducing the number of individuals’ sex partners [was] more important than promoting the use of condoms” (Hearst and Chen 2004, 39). Several studies, in turn, support a “balanced ‘ABC’ approach” combining partner reduction, delayed sexual debut, and consistent condom use – in particular among high-risk “bridge” populations – as the most effective way of reducing HIV transmission in a general population (Shelton *et al.* 2004; see also Potts *et al.* 2008; Genuis and Genuis 2005).

Regarding condom promotion, research indicates the limits of condom-only strategies in helping arrest generalized HIV epidemics in sub-Saharan Africa. Campbell and Williams (2001, 139) note that condom use among highly vulnerable groups in South Africa, such as miners, sex workers, and young people, is likely to be undermined by “economic and ideological constraints.” Genuis and Genuis (2005) further observe how proper and consistent use of condoms is limited, especially among young people, and that condoms also offer only minimal protection from some STIs that can heighten risk of HIV transmission. Potts *et al.* (2008, 749) find “no evidence of a primary role” of condom use in arresting generalized epidemics. Issues such as cost and availability are also non-negligible in their impact on condom use (Hearst and Chen 2004).

In their wide-ranging summary of prevention research in sub-Saharan Africa, Potts *et al.* (2008, 749) concluded that “[t]he largest investments in AIDS prevention targeted to the general population are being made in interventions where the evidence for large-scale impact is uncertain.” Besides condom use, they cite voluntary counseling and testing (VCT), treatment of STIs, vaccines and microbicides, and abstinence as primary prevention strategies which empirically do not and are statistically unlikely to have a significant impact on curbing generalized epidemics. This is not to suggest that these strategies are useless; VCT, for instance, “is recognised as an important element of any effective HIV prevention and care programme” (Njagi and Maharaj 2006). However, as Potts *et al.* (2008) point out, consistent

risk reduction after VCT has only been observed in samples of individuals who test positive, but not in those who test negative. A strategy known to work for HIV prevention is male circumcision, proven to reduce the risk of HIV infection by as much as 60% (Potts *et al.* 2008). These authors conclude, however, that this strategy is only effective when “combined with behavior change, especially promotion of partner reduction and consistent condom use” (*ibid.*, 750).

For its part, behavior change is recognized as a complex processes requiring multidimensional approaches. Parker (2001), for one, has noted how the social and cultural determinants of human interactions in general, and sexual behavior in particular, are attracting increasing attention in HIV prevention literature. Other authors have shown how cultural expectations and popular understandings of sexual roles impact on, among other things, men’s desire to have multiple partners (Rao Gupta 2000), willingness to use condoms (Allen *et al.* 1992), and perceptions of “clean” or “unclean” partners (MacPhail 2003). Mane and Aggleton (2001, 26) have even argued that high-risk sexual behaviors are frequently “acceptable and socially rewarded.” Individuals are therefore not totally free to evaluate and change their behaviors, and prevention cannot target individuals in a vacuum, providing only information and materials. Instead, successful HIV prevention must address cultural systems and structural factors, including socio-economic inequality and patriarchy, which establish sexual roles, define “right/wrong” practices, and shape attitudes and behaviors (Parker 2001; Mane and Aggleton 2001; Campbell and Williams 2001).

To that end, many studies have concluded that curbing generalized HIV epidemics requires wide-ranging commitments from governments, international actors, civil society, and affected populations. Shelton *et al.* (2004, 893) describe how “explicit and repeated presidential pronouncements and the committed engagement of faith based organisations, the governmental apparatus, the military, the health system, and community based and mass communications” led to a “tipping point” in the Ugandan epidemic, after which “avoiding risky sex has become the community norm.” Campbell and Williams (2001) note a similar success story in Senegal and further that, in contrast, ambivalent and contradictory government engagement have hampered HIV prevention in South Africa since the 1990s. While few studies exist about HIV prevention success stories in sub-Saharan Africa – because there have been painfully few – the international consensus is that behavior change must be

the central goal of prevention efforts, and that all levels of society must be implicated (Parker 2001; Shelton *et al.* 2004; Hearst and Chen 2004; Campbell and Williams 2001).

That being said, epidemics among highly vulnerable groups like MSM are functionally different from those affecting general populations: they are fueled by riskier, often clandestine and illegal practices, and members of these groups often face social stigma, marginalization, denial, or physical and legal repression (UNAIDS 2006; amfAR 2006; FHI 2008; Johnson 2007). While drug users and sex workers have increasingly found a place in AIDS programming in sub-Saharan Africa, homophobia and denial have led to a “special vulnerability” among MSM that must be taken into account in HIV/AIDS programming (Johnson 2007, viii). The next two sections will explore the current literature on HIV prevention for MSM and the factors affecting the design and implementation of HIV prevention interventions for MSM in sub-Saharan Africa.

2.3.2 HIV Prevention for MSM: What about sub-Saharan Africa?

As Johnson (2007, iii) has argued, “[t]he ravages of AIDS fall hardest on those most marginalized in our societies: women, the poor, LGBT’s.” Unlike the first two groups however, which have received much attention in HIV/AIDS programming, “a wall of silence” continues to isolate MSM from mainstream prevention discourses in sub-Saharan Africa (*ibid*, 1). To date, most research about HIV prevention for MSM has been conducted outside sub-Saharan Africa. However, these findings can nonetheless serve as a foundation for thinking about HIV prevention for MSM on the continent.

Much research exists confirming that targeted interventions for MSM can bring about protective behavior change. In their meta-analysis of HIV prevention research conducted in the United States, Johnson *et al.* (2002, S121) found a 26% decline in UAI following intervention, with the most effective strategies incorporating interpersonal skills development – “training in negotiation, disclosure, and communication” – and a strong focus on younger or more at-risk MSM in community-level delivery formats. They concluded that “[r]educing the occurrence of unprotected anal sex by 26% among MSM can result in substantially reduced transmission of HIV and STDs,” with particular impact on MSM living in environments with high levels of UAI, sexual networking, and HIV/STI prevalence (*ibid*, S125). A similar meta-analysis incorporating data from North America, Europe, Latin America, and Oceania largely confirmed these results (Herbst *et al.* 2005). It found that behavioral interventions produced

“a 23% reduction in odds of UAI and a 61% increase in odds of condom use during anal sex,” and that the best interventions were those that taught interpersonal skills, were delivered in several formats (individual, group, community), and involved multiple sessions over at least three weeks (*ibid*, 237).

These reviews also revealed several important considerations. First, interventions can produce durable results, especially if delivered over more than one session. Second, behavior-change interventions for MSM can be both cost-effective – “costing less than what society is willing to pay for health” – and cost-saving – “costing less than the medical and social costs of the infections averted” (Johnson *et al.* 2002, S127). Furthermore, Herbst *et al.* (2005, 237) found that interventions were most effective if they incorporated behavior-change theories, such as “diffusion of innovations,” whereby “popular people... endorse innovations... [to] help refine behavioral norms and standards.” This is similar to the successful peer-led, social network-level intervention approach among Russian and Bulgarian MSM described by Amirkhanian *et al.* (2003).

These two meta-analyses come with warnings, however. On the one hand, self-reporting of sexual behavior – on which most prevention studies were based – is likely to be influenced by recall bias and “socially desirable responding” (Herbst *et al.* 2005, 238). On the other hand, interventions bringing together groups of MSM may unintentionally create new opportunities for sexual networking, which could be all the more problematic if the participating MSM are considered to be at highest risk (Johnson *et al.* 2002). Nonetheless, both reviews believe targeting highest-risk MSM could have important community-level impacts on HIV transmission.

While behavior-change interventions are known to work in the global North and Latin America, it cannot be assumed that the same strategies would produce the same results in sub-Saharan Africa. No African studies were included in either review, for the self-evident reason that as of 2005, none existed. What is known about sub-Saharan Africa, however, is that MSM often do not see themselves or their practices reflected in existing prevention programming. As mentioned earlier, these strategies are often “heterocentric,” depicting only male-female couples and defining “sex” as vaginal intercourse (Johnson 2007; Henry 2008; Phillips 2004). As such, anal sex is often perceived to be as safe or safer than vaginal intercourse, leading MSM to unwittingly put themselves and their partners – male and female

– at higher risk for HIV transmission. It is for this reason that Johnson (2007, 2) believes that “[a]nti-gay discrimination is fueling the African HIV/AIDS epidemic.”

At present, only one empirical study has investigated HIV prevention interventions for MSM in sub-Saharan Africa, and the results are promising. Following up on their original study, Wade *et al.* (2008) assessed the impact of three prevention interventions targeting MSM: “an access to health care program for STIs and for HIV, a campaign to raise awareness on sexual risk and an appeal in defence of MSM targeting decision makers.” They found that following intervention, HIV prevalence remained stable (22%) among all MSM, but declined in younger MSM. Reported cases of STIs also decreased across all age groups. While the frequency of various sexual activities remained steady, condom use surged, to as much as 75.3% during receptive anal intercourse and 85% during commercial sex (“gave money”). Condom use with female partners also increased markedly. The authors concluded that “[p]revention interventions targeted towards [MSM] led to a reduction of risk behaviours in this group, showing their efficiency.” This bodes well for further intervention in sub-Saharan Africa.

Despite a severe lack of data on intervention effectiveness and strategies – even Wade *et al.* (2008) do not explain the interventions in detail, as the study has yet to be published – many epidemiological studies have also collected information on needs, expectations, and potential strategies for HIV prevention among MSM in sub-Saharan Africa. Parkinson (2008), summarizing the results of a “most at-risk populations” (MARPs) stakeholder meeting in Kenya, identified the decriminalization of same-sex conduct, the legal recognition of MSM organizations, technical and intervention capacity-building among MSM and within the health care sector, and better data collection as “key priorities” for improving HIV prevention for MSM. A UNAIDS stakeholder meeting came to similar conclusions, arguing for “reliable epidemiological indicators,” the inclusion of MSM in national HIV/AIDS discussions, and the promotion of “sex-positive” approaches, to undo the fact that MSM “have been told so often that their sex is bad” (UNAIDS 2005, 4-5).

Also highlighted was the need to guarantee access to, and encourage use of, water-based lubricants for anal sex – a major challenge in hostile contexts (URD 2006; PlusNews 2008; Alternatives-Cameroun 2007; FHI 2008). Georges Kanuma has commented, “I had never heard of [water-based lubricants], and I know if I hadn’t heard of it, then definitely most [MSM] in Burundi didn’t know about it either” (PlusNews 2008). Wade *et al.* (2005,

2139) similarly noted that “the use of lubricating gel was very rarely reported.” Henry (2008) found that 52.5% of MSM in Douala, Cameroon, did not use water-based lubricants due to their lack of availability, while 21.2% cited cost and 7.6% said they felt fear or shame when purchasing it in a pharmacy. This is a particularly important element in prevention among MSM, as oil-based lubricants – e.g., Vaseline – can damage the integrity of latex condoms, and using no lubricant at all can increase the risk of injury, and therefore HIV transmission, during anal intercourse.

Other elements perceived as critical for HIV prevention among MSM in sub-Saharan Africa include: networking service providers to integrate MSM issues into national health care systems (Diop *et al.* 2008); developing community-based MSM organizations, to provide “comprehensive care services” and encourage community mobilization (Cutler *et al.* 2008); improving access to VCT services (Angala *et al.* 2006); addressing homophobia in the health care sector (Adebajo *et al.* 2006); and designing anxiety- and stigma-reduction strategies to encourage MSM to test for HIV (Sandfort *et al.* 2008b). New international networks, such as Africagay (www.africagay.org), as well as the more established International Gay and Lesbian Human Rights Campaign (www.iglhrc.org) and Pan-African International Lesbian and Gay Association (africa.ilga.org), are striving to “encourage emerging mobilization and consolidate the willingness for commitment from [African community-based MSM organizations]” and “advocate the acknowledgement of sexual minorities in Africa, at international and national levels” (Cutler *et al.* 2008). Johnson (2007) cites a small, but growing number of African NGOs beginning to mobilize around the “MSM issue.”

As the criminalization of homosexual conduct threatens such endeavors, African NGOs appear to be adopting “umbrella approaches,” using human rights or public health as platforms from which to negotiate for greater recognition of MSM (PlusNews 2008). Virtually no published empirical data exists on the instrumentalization of these approaches – this study may well be first to examine in detail the interventions carried out by an African NGO targeting MSM – and very few associations have websites detailing their activities. One of these associations, ARCAD Sida in Mali, pursues the following strategy: identifying sites where MSM congregate; recruiting community peer leaders to reach MSM; training community organizers to address health, rights, and other issues important with MSM; organizing educational workshops and in-home discussion groups to discuss prevention methods; and distributing condoms and water-based lubricant in gay meeting spots (ARCAD

Sida 2007). This association is not an “NGO of MSM,” however, but rather a national HIV/AIDS organization with a “*Programme MSM*.” Other African associations known to work with MSM on HIV prevention, including the *Association Nationale de Soutien aux Séropositifs*⁸ in Burundi (www.anss.bi), Liverpool VCT in Kenya (www.liverpoolvct.org), and the *Alliance Nationale Contre le Sida*⁹ in Senegal (www.ancs.sn), do not detail their interventions on their websites. Alternatives-Cameroun does not have a website, but releases annual reports detailing its initiatives. While it is known that several other African NGOs and CBOs are interested in working with MSM on HIV/AIDS issues, this engagement is only in its earliest phases. Most of these associations still lack the structural, performance, and relational capacities necessary to intervene effectively (Cutler *et al.* 2008; AIDES/Sidaction 2008).

2.3.3 Factors Affecting Design and Implementation of Interventions

While the literature is scarce on African associations and their interventions for MSM, some information does exist about barriers to participation for MSM and the factors which affect the design and implementation of these interventions. Perhaps the most important factor impacting on interventions in Africa is secrecy, denial, and silence surrounding homosexuality: as Teunis (2001, 179) concluded in his anthropological study of MSM in Senegal, “[s]ecrecy exists in Africa in the absence of privacy” (see also Macauley 2009). Social taboos and stigma make it difficult to find MSM and engage them openly about their practices, forcing interventions underground and reinforcing the “hidden” nature of homosexuality in Africa (*ibid*; see also McFarland and Cáceres 2001). As Jean Rirangira from Burundi’s *Comité Nationale de Lutte contre le Sida*¹⁰ has noted, “We realise that they are a marginalised group; we have started to invite them for meetings through their NGO [ARDHO], but the difficulty is we don’t know who most of them are or how to reach them” (PlusNews 2008). George Kanuma, the head of ARDHO, describes the “cloak-and-dagger” manner in which condoms and lubricants are distributed to “secretly homosexual men” in Burundi, who are fearful of associating with the association (*ibid*). The “wall of silence [surrounding] AIDS and same-sex practices in Africa” thus undermines interventions in two ways: by preventing MSM from participating and by inhibiting associations from reaching

⁸ National Association for the Support of HIV-Positive People

⁹ National Alliance against AIDS

¹⁰ National Committee for the Fight against AIDS

them (Johnson 2007, 1). At the same time, it must be noted that HIV/AIDS programming could put MSM at risk if it raises their visibility without establishing safeguards (UNAIDS 2005). This highlights a “catch-22” for prevention interventions: to help MSM lower their risk of HIV infection, associations must reach MSM – but “uncovering” MSM may increase their risk of stigmatization, violence, or arrest.

The criminalization of homosexual conduct itself is a major factor affecting intervention design and implementation (Johnson 2007; Polgreen 2009; UNAIDS 2005; Parkinson 2008). Not only does it keep MSM “hidden” and create barriers to disclosure in healthcare settings, but it also prevents MSM from forming associations or working with existing NGOs to “provide points of access, assist in the development of measures, and guide appropriate use of data” (McFarland and Cáceres 2001, S23). Furthermore, in many countries MSM cannot legally register their associations. This limits their access to funding, undermines their ability to meet, and legitimizes police harassment and public stigmatization (Parkinson 2008), while also reinforcing mistrust between MSM communities and governments, research institutions, and service providers (McFarland and Cáceres 2001; see also Angala *et al.* 2006). Finally, criminalization of homosexual conduct impacts negatively on both the quantity and quality of data collected about MSM, leading to interventions “that are neither evidence-based nor evidence-informed” (*ibid*; see also UNAIDS 2005; McFarland and Cáceres 2001). UNAIDS (2005, 10) highlights a vicious circle in attempts to implement effective interventions: “there is a lack of funding because there is a lack of evidence; and there is a lack of evidence because there is a lacking of funding.” The decriminalization of homosexual conduct is thus considered a top priority among African and international NGOs alike (Alternatives-Cameroun 2007; Parkinson 2008; Johnson 2007).

Fear of being “outed” as MSM or HIV-positive – or both – is a frequently-cited barrier to participation and therefore a factor influencing intervention design and implementation (Adebajo *et al.* 2006; McFarland and Cáceres 2001; URD 2006). This is attributed not just to homophobic healthcare providers (Adebajo *et al.* 2006, URD 2006), but also to “increasing HIV stigma within MSM communities” (Parkinson 2008). “Testing anxiety,” for fear of a positive result or of disclosure as MSM, has emerged as a “major barrier” to HIV prevention in some settings (Sandfort *et al.* 2008b). In one study, only 10.3% of MSM collected their results after testing (Adebajo *et al.* 2006). While one study found that a “significant number

of men felt able to disclose male sexual partners during VCT” (Angala *et al.* 2006), it is clear that maintaining the trust of MSM is crucial for interventions.

Finally, skills shortages and lack of technical capacity appear to be important constraints on intervention design and implementation (Parkinson 2008), as does the extent to which MSM are involved in research and policy-making (UNAIDS 2005). There is agreement that overall capacity-building is critical for launching effective interventions for MSM. This includes not just medical and logistical knowledge, but also administrative and networking capabilities (Cutler *et al.* 2008; AIDES/Sidaction 2008). Internet access is also emerging as an important element for reaching “hidden” MSM and for facilitating exchange between MSM organizations (*ibid*; UNAIDS 2005). Building capacity among associations in resource-poor settings like sub-Saharan Africa, however, will require persistent efforts and innovative strategies for sustainable NGO/CBO development. This task remains a major preoccupation for African and international civil society actors alike.

2.4 Summary

The chapter provided a comprehensive overview of existing literature in three crucial areas for understanding the factors affecting design and implementation of HIV prevention interventions for MSM in sub-Saharan Africa: perceptions of homosexuality in Africa; the position of MSM in Africa’s “heterosexual” HIV/AIDS epidemics; and the theory and practice of HIV prevention for MSM on the continent. Huge gaps remain, however. The first epidemiological study of African MSM dates to just 2005, and very little research on existing prevention interventions, and the associations designing and implementing them, has been conducted. The findings of this study – a case study of Alternatives-Cameroun, a local NGO carrying out HIV prevention interventions for MSM in Cameroon – therefore constitutes a first step towards filling this gap.

Chapter 3: METHODOLOGY

A case study of Alternatives-Cameroun, an MSM-focused NGO based in Douala, was used to explore the factors affecting design and implementation of HIV prevention interventions for MSM in Cameroon. Within this framework, two qualitative research methods were employed to investigate the format and content of interventions, as well as the actors undertaking them.

This chapter will start by describing the study setting, the Republic of Cameroon, with particular attention to its national HIV/AIDS response. Second, Alternatives-Cameroun will be presented as this project's case study; its history, structure, and current programming will all be highlighted. Third, the research methods used for this study – stakeholder interviews and personal observation – will be explained, including the advantages and disadvantages of each method. Finally, a discussion of larger limitations and ethical issues related to this study will complete the chapter.

3.1 Study Setting: Cameroon

Located “in the heart of Africa,” straddling the frontier between Central and West Africa, the Republic of Cameroon can be called “Africa in miniature” for its geographic, cultural, and linguistic diversity (UN 2000, 1). It has a population of roughly 18.5 million, divided among 230 ethnic groups and two major language communities: eight of the country's ten provinces are francophone, while two are anglophone, reflecting the country's unique colonial history. West and East Cameroon achieved independence from Britain and France, respectively, and were reunited on 1 October 1961. The national capital is Yaoundé, situated in the country's Center Province, while the economic capital, major port city, and largest agglomeration is Douala (pop. 2 million), in the Littoral Province. Both are francophone cities. In 2008, Cameroon ranked 150/179 on the Human Development Index (UNDP 2008) and was classified as a “lower middle income country” (World Bank 2008) – making it relatively wealthy and developed by African standards.

Despite this relative prosperity, however, Cameroon has among the highest general-population HIV prevalence in the world: 5.5% among adults between 15 and 49 (CNLS 2008). Since 2000, the Cameroonian government has engaged in multi-sectoral efforts to stem the spread of HIV/AIDS, establishing two national strategic plans (2000-2005, 2006-

2010) and committing resources for both research and interventions. However, as in most of sub-Saharan Africa, the national response is strongly “heterocentric,” taking the position that “young people and women represent the hidden face of the epidemic,” with peak prevalence rates of 9% and 6.8%, respectively (*ibid*, 17). The national plan enjoys multisectoral support and is comprehensive, including funding for prevention activities, HIV testing, large-scale communication campaigns, condom distribution, and free provision of antiretroviral (ARV) medications. It also expressly targets “specific most at-risk groups,” notably truckers, people living along the Chad-Cameroon oil pipeline, sex workers, and the armed forces (*ibid*). MSM, however, are completely absent from Cameroon’s response to the HIV/AIDS epidemic. In the country’s 2008 UNGASS¹¹ progress report, MSM receive no mention at all in the narrative portion; in the second part, with charts to fill in for specific activities, all lines mentioning MSM are marked “S/O” – the French equivalent of “N/A” (*ibid*, 53; 67). Despite growing evidence of elevated prevalence and high levels of risk-taking among MSM, in Cameroon and across sub-Saharan Africa, MSM are still considered “not applicable” to HIV/AIDS programming in Cameroon.

3.2 Presentation of Alternatives-Cameroun

Alternatives-Cameroun was launched informally in April 2006 in reaction to the “Yaoundé 11” case, as well as to a general concern among its three founders – a medical doctor with experience in HIV/AIDS programming, a doctoral candidate in sociology, and a student activist – for the position of sexual minorities in Cameroon (Gueboguo [pending]). Legally recognized since October 2006, Alternatives-Cameroun’s mission is to fight “for the respect of human rights, notably the right to medical care and services, to information, to training opportunities, and to education for vulnerable people and victims of discrimination” (*ibid*, 10). In statute, the association serves “all people who have been victims of discrimination, and specifically those who have been discriminated against on the basis of their sexual orientation” (Alternatives-Cameroun 2007). In practice, however, it works almost exclusively with MSM, primarily in the city of Douala, but also to a limited extent in Yaoundé.

At the time of this study, Alternatives-Cameroun had 30 active members and was run by a ten-member Executive Board, including: five administrators, four heads of thematic

¹¹ United Nations General Assembly Special Session on HIV and AIDS

cellules (units), and one secretary. Within each unit, several *animateurs* (peer educators) carry out the association's activities in the field. Alternatives-Cameroun also runs the "Access Centre" in downtown Douala, a care-and-treatment facility for MSM that also serves as the association's administrative headquarters and as a community center for local *nkouandengués*.¹²

Alternatives-Cameroun works in the areas of HIV/AIDS, human rights, legal advocacy, psychosocial support, and education. Despite this broad mission, most of the association's financial and material resources are devoted to preventing and treating HIV/AIDS among MSM. Under the direction of the Sexual Health and Prevention Unit (SHPU), the association currently runs four types of HIV prevention intervention, collectively called the "proximity approach to prevention:" bimonthly outreach in bars and cafés; monthly *causeries éducatives* (educational workshops) at the Access Centre; sensitization and outreach via gay chat and dating websites; and *grins* (pronounced "gran"), whereby community members host interventions at their homes for 10-15 of their friends. This last format, in particular, helps the association reach MSM who do not frequent gay establishments or the Access Centre. During all face-to-face interventions, beneficiaries receive condoms and water-based lubricant, as well as information on risk-reduction strategies, STIs, medical care options, and legal recourse in case of arrest. HIV-positive beneficiaries can also receive free ARV treatments and participate in a confidential support group, led by a psychosocial counselor.

While domestically the association keeps a low profile, it is well-known internationally for its work with MSM in Cameroon (IGLHRC 2008; IRIN News 2008). Association leaders regularly participate in international fora, including the 2008 AIDS conference in Mexico City and the 2008 ICASA meeting in Dakar. At present, Alternatives-Cameroun is mostly foreign-funded, with its main financial partners in France, the United States, and elsewhere in Europe. Association members also pay dues to support the association's initiatives (Alternatives-Cameroun 2007).

3.3 Why Alternatives-Cameroun?

As mentioned in the previous chapter, very few local or international NGOs currently work with MSM in sub-Saharan Africa, despite the epidemiological, political, and moral

¹² *Nkouandengué* is a local term used to describe MSM, not all of whom necessarily identify as gay, homosexual, etc. It serves as a "code name" in everyday life, as the term is not generally known within Cameroonian society.

imperative for such programming. Silence, stigmatization, and criminalization have further kept the “MSM issue” off national HIV/AIDS agendas in most African countries and reinforced the hostile contexts in which MSM-friendly NGOs must operate. As such, from the outset, it was clear that accomplishing this project’s objectives would require finding existing interventions and accessing the actors designing and implementing them, without putting these actors at risk.

Among the few African associations actively involved in MSM issues, a number of practical considerations determined the selection of Alternatives-Cameroun as this project’s case study: breadth, depth, and length of experience with HIV prevention; organization size and stability; physical availability and willingness of stakeholders to be interviewed; and the possibility for financial support. There were also context-related considerations: for example, any case study association would need to be secure enough to host a non-African researcher – potentially increasing its local visibility – without compromising its safety. Initial contact with Alternatives-Cameroun was made through Sidaction, a French HIV/AIDS organization and key financial partner. Following a face-to-face meeting in Paris, the president of Alternatives-Cameroun confirmed his association’s willingness – even eagerness – to welcome a foreign researcher and participate in this project. An agreement was thus reached whereby Sidaction would fund this project’s fieldwork and Alternatives-Cameroun would serve as its case study.

3.4 Research Methods

A case study methodology was used to explore the factors affecting design and implementation HIV prevention interventions for MSM in Cameroon. As this study focused on interventions, and only one Cameroonian NGO is currently doing such work, it seemed clear that a case study of this association would be the most efficient way to access the stakeholders, beneficiaries, and contexts implicated in these interventions. Within this framework, two qualitative research methods were employed: stakeholder interviews and personal observation. It made sense to use qualitative research methods since this study focused on unquantifiable variables: experiences, motivations, perceptions, interactions, and processes. Fieldwork was conducted in Douala and Yaoundé, Cameroon, over a five-week period in November-December 2008, followed by a one-month internship with Sidaction in Paris.

3.4.1 Stakeholder Interviews

Semi-structured interviews were conducted with thirteen stakeholders in Alternatives-Cameroun. For this study, a “stakeholder” was defined as someone actively involved in designing and/or implementing the association’s HIV prevention interventions. For Alternatives-Cameroun, this is not limited to peer educators; stakeholders also include administrative personnel, association beneficiaries, and key foreign partners. The stakeholders interviewed for this project include:

- 5 members of Alternatives-Cameroun’s Executive Board
- 3 peer educators in the SHPU
- 2 members who are beneficiaries of the association’s care and treatment services
- 1 local human rights lawyer
- 2 program coordinators at French NGOs, charged with running their partnerships with Alternatives-Cameroun

Stakeholders were selected with the help of Sidaction and the president of Alternatives-Cameroun, as well as through personal observation of who was actively involved on the ground. Due to logistical and technical constraints, only nine interviews were recorded. As such, direct quotations used in Chapter 4 come exclusively from these interviews. Information gathered during the other four interviews, however, was nonetheless critical for this study and is incorporated in all analysis.

As interviews were semi-structured, the interview instrument (see Appendices 1 and 2) served as a basis for discussion rather than a rigid roadmap. Interviews were conducted in French, averaged one hour in length, and centered around five topics: personal engagement in Alternatives-Cameroun; homosexuality in Cameroon; the mission and vision of Alternatives-Cameroun; factors influencing intervention design (format and content) and implementation (the “lived experience”); and organizational dynamics and sustainability. In line with the “theory-driven interview” approach (Pawson 1996), varying perspectives on HIV prevention and intervention theory were presented – drawn from academic literature and observations made during fieldwork – which interviewees then expanded on or critiqued, according to their views and experiences.

Conducting semi-structured stakeholder interviews offered several advantages for this study. First, it allowed for the collection of a wide range of perspectives among the various actors implicated in Alternatives-Cameroun’s work, presented in their own words. Since “stakeholder” was broadly defined, these views reflected a broad spectrum of professional,

educational, and personal influences on the way these actors work, why they chose to get involved, and what has motivated their decisions regarding intervention design and implementation. Incorporating a “theory-driven” approach facilitated nuanced discussions comparing prevailing prevention intervention strategies with those undertaken by Alternatives-Cameroun.

At the same time, interviewing had some disadvantages that needed to be controlled for. In Cameroon’s repressive context, most stakeholders are only “out” within Alternatives-Cameroun, causing an atmosphere heavy with the personal “baggage” of individual members – baggage which cannot be opened elsewhere. This led over time to an accumulation of tension that was, in part, released through the research process; one French stakeholder compared the researcher’s presence at Alternatives-Cameroun to quickly opening a pressure cooker. Furthermore, it became apparent that some stakeholders approached the interview process with agendas, both personal and professional, and that the researcher was perceived by some as a conduit for advancing these agendas among Alternatives-Cameroun’s European partners. It is thus possible that some information collected during interviews was spun to suit these agendas and was therefore not objective. Throughout the interview process, the researcher took precautions to monitor discussions for “sales pitches” and reemphasize in each instance the specific aims and objectives of this study.

3.4.2 Personal Observation

Personal observation was defined for this project as “collecting data by walking in stakeholders’ shoes,” i.e., by interacting with stakeholders in their daily routines at Alternatives-Cameroun and participating actively in the association’s activities. Such situations included: HIV prevention interventions at the Access Centre and in the field in Douala; informal discussions with members and beneficiaries; and an internship with Sidaction in Paris, working on aspects related to capacity-building and funding priorities for Alternatives-Cameroun.

Regarding prevention interventions specifically, the researcher was present at the following: one monthly General Assembly meeting, at which prevention approaches were debated; two outreach activities at gay nightspots in Douala; one online outreach session with members of the SHPU; one educational workshop at the Access Centre; and one meeting of the HIV/AIDS support group. All of these afforded insight into what interventions are being

carried out, what information is being discussed, and how beneficiaries and actors alike experience these interventions. These interactions also reinforced the interview process: a sample of key stakeholders naturally emerged through observation, as selected interviewees were those who “spoke with their feet,” visibly and actively participating in Alternatives-Cameroun’s HIV prevention work.

Finally, the internship component provided access to the mechanics and constraints of Alternatives-Cameroun’s foreign partnerships. Interactions with partnership coordinators highlighted both the international engagement of Alternatives-Cameroun and the global context of HIV/AIDS programming in which it operates. It became clear, for example, that even simple interventions – like the distribution of water-based lubricant – were subject to important debates about funding and supply, accountability, and distribution of responsibilities.

Personal observation offered several important advantages to this project. First, while interviewees presented facts and opinions, personal observation provided insights into overarching dynamics, mechanisms, and processes that tended to go unnoticed or unappreciated by the stakeholders who regularly participate in them. Also, as mentioned earlier, stakeholders hold strong personal convictions about the association’s mission and actions and sometimes used interviews to “sell” their views. Personal observation, in contrast, allowed data to naturally emerge from actual contexts and informal interactions. When working together on interventions, for example, stakeholders often acted more conciliatory and flexible than they appeared during interviews.

Finally, personal observation allowed for investigation into the gaps between theory and practice, gaps not readily apparent to stakeholders. For instance, many peer educators do not know *why* certain strategies or approaches have been chosen for the Cameroonian context – for them, there is no other context. Those at the head of the association, for their part, are acutely aware of prevention research conducted in Africa and abroad and are able to explain clearly why certain actions would be untenable among Cameroonian MSM. These leaders, however, are not often active “in the field” – a job left to the peer educators. During interventions, then, personal observation allowed the researcher to witness firsthand how practices had been adapted to the Cameroonian context and then query peer educators about these practices. In short, personal observation both supplemented and complemented stakeholder interviews in providing a well-rounded picture of Alternatives-Cameroun’s HIV

prevention interventions. Without the internship component, it would also have been difficult to report credibly on external factors impacting on the design and implementation of the association's work.

The disadvantages of personal observation must also be noted. For one, as an ethnographic method, its full exploitation requires long-term access to and immersion in the subject culture – actions which certainly take longer than five weeks in the field and one month in a foreign partner's office. As such, one-time phenomena may have been misinterpreted as recurring issues and attributed greater weight than they deserve. Stakeholder interviews helped control for this, however: the researcher asked follow-up questions – such as, “I observed this-or-that; it seems to be a problem. Do you agree with my assessment?” – which stakeholders could then confirm or refute. Also, stakeholder participation in interventions was cited as having increased due to the researcher's presence, out of both curiosity and an effort to put forth a good face for the association. Real participation levels were in turn assessed in interviews, and future interviewees were “vetted” based on others' assessments of their importance as stakeholders. In short, attempts were made to balance the two research methods against each other.

Subjectivity is also an important disadvantage of personal observation. In each situation, the researcher had to constantly ask himself: Am I really observing this, or am I just projecting my expectations and convictions onto it? For instance, while the researcher is familiar with prevention research – what works and what does not – peer educators are largely unaware, despite their critical roles as implementers. In Alternatives-Cameroun hostile and high-prevalence context, where the difference between effective and ineffective interventions could mean someone contracts or transmits HIV, the “activist urge” to contribute directly to strengthening programming is powerful – although this is clearly outside the scope of this project and the research process itself. By keeping a daily journal, the researcher strove to keep his personal opinions in check and learn from, rather than counsel or critique, Alternatives-Cameroun. This process went beyond prevention strategies: issues related to sexual orientation, revelation of HIV status, and LGBT activism are ever-present and highly contentious within the association. Without careful precautions – such as journaling and sustained reflection on personal observations – it would have been easy to become emotionally implicated in the association's complex dynamic, and thereby compromise the research process.

3.5 Limitations

This project has a number of inherent limitations. First and foremost, Alternatives-Cameroun is just one association working mostly in one city, in one country. As such, its experiences and constraints cannot be considered representative of the rest of Cameroon, let alone Africa. Moreover, Alternatives-Cameroun has many more international partners than could be investigated given this project's time and funding constraints. It is therefore possible that some external factors were over- or underemphasized by some stakeholders, without sufficient counterbalancing from others. It is hoped, however, that the relatively large number of interviews and informal consultations – bearing in mind that Alternatives-Cameroun only has 30 members – have provided some buffer against this bias.

Secondly, Alternatives-Cameroun is a young association, with just over two years of experience. Therefore, while design and implementation of interventions could be explored, their evaluation and the association's capitalization on follow-up data could not be examined. Intervention effectiveness is also firmly outside the scope of this project: due to the persistent lack of epidemiological data and the qualitative approach to this study, it is impossible to draw conclusions regarding Alternatives-Cameroun's impact on HIV incidence or prevalence among MSM in Cameroon. The findings and conclusions presented should be taken, therefore, as relating only to the factors influencing two key processes at Alternatives-Cameroun: the design and the implementation of HIV prevention interventions.

In that vein, the one-month internship at Sidaction in Paris provided only a restricted picture of the larger international collaborative network in which Alternatives-Cameroun is embedded. Moreover, the individuals currently overseeing the partnership were not implicated in Alternatives-Cameroun's earliest collaboration with its French partners. As such, their perspectives may lack some authority about external factors affecting the design and implementation of current interventions. The internship provided important insight into the mechanics and constraints of international partnerships, but only limited perspectives on their evolution over time and their "big picture" implications for Alternatives-Cameroun. More research is clearly needed in this area.

Finally, given the activist nature of the association – and the courage required by all outreach actors – perspectives and opinions were often highly subjective, reflecting reality as perceived by individuals. The information collected therefore has no statistical significance or factual robustness. That being said, this was not the intent of this project. Instead, the goal

was to collect experiences and perspectives around Alternatives-Cameroun's HIV prevention interventions for MSM, to explore the factors affecting their design and implementation. As mentioned, the researcher kept a detailed daily journal, in which both stakeholder and personal observations were recorded, as a precaution against subjectivity in the data. Every effort was then made to "take a step back," situate these observations within the larger framework of the project, and counterbalance those which proved fleeting or inaccurate.

3.6 Ethical Considerations

Ethical approval for this study was received from the University of KwaZulu-Natal during the proposal process, and every effort was made to adhere to strict ethical standards in undertaking this project. Alternatives-Cameroun, as an association, participated freely and willingly as this project's case study, and individual interviewees all offered their informed consent (written or verbal, depending on the situation) prior to interviews. At no time were interviewees asked about individual HIV status or medical history, and any such information revealed was not included in this report. Participant confidentiality was ensured by assigning interviewees a stakeholder number. Interview recordings and their transcriptions are password-protected on the researcher's computer and will not be used or diffused for any other purpose, without the prior consent of interviewees.

Alternatives-Cameroun operates in a hostile and repressive context, and the presence of a non-African researcher had the potential to temporarily increase the visibility of the association. Culturally, this could have been problematic: it was explained to the researcher that Cameroonians believe non-Africans only come to Cameroon for business or sex, and that if a white man and a black man are seen together in public, it is assumed they are homosexual. In fact, the researcher was twice taunted as "*homosexuel*" while socializing with members of Alternatives-Cameroun. On top of this, several locals inquired about the researcher's extended stay in Cameroon, to which a neutral response was always given: "I am here doing research on HIV/AIDS for my master's dissertation."

Visibility is no small issue for Alternatives-Cameroun, but all members agreed to take the risk of welcoming the researcher. Many association members, even those most active in HIV prevention, have never been outside Cameroon or worked with other HIV/AIDS organizations. A feeling of isolation is prevalent among those who intervene "in the field."

The researcher's presence was thus viewed as offering moral justification for Alternatives-Cameroun's continued intervention among MSM, despite the many risks involved.

As mentioned, the fieldwork portion of this project was funded by Sidaction, a French HIV/AIDS organization. In 2008, Sidaction and one of its French partner associations, AIDES, received funding from the French Ministry of Foreign Affairs to provide financial, logistical, and programmatic assistance to NGOs in West and Central Africa seeking to launch HIV/AIDS interventions for MSM. One component of this joint project is research aimed at exploring and evaluating these associations, in order to highlight priorities for capacity-building and intervention. Some of the data collected through this study was used, during the internship process, to contribute to this research component. Both Sidaction and Alternatives-Cameroun agreed to this from the outset. However, the funding from Sidaction did not impact on the design of this study, which was thoroughly elaborated prior to the fieldwork process. No contingencies or desired outcomes were prescribed, and all data and this dissertation itself remain the sole property of the researcher.

3.7 Summary

This chapter presented the methodology and research methods used to explore the factors affecting design and implementation of Alternatives-Cameroun's HIV prevention interventions for MSM in Cameroon. The study setting, Cameroon, and the case study association were described in detail, highlighting the unique and difficult position which Alternatives-Cameroun occupies in its local context. The two qualitative research methods selected for this study – stakeholder interviews and personal observation – were then presented and their respective advantages and disadvantages elucidated. Finally, the overarching limitations and ethical considerations associated with this project were explained, with a focus on the precautions taken to guarantee objectivity in data collection and safety for study participants.

Chapter 4: RESULTS AND DISCUSSION

The previous chapters brought attention to homosexuality in sub-Saharan Africa and highlighted the position of MSM as a high-risk, vulnerable group within the context of Africa's "heterosexual" HIV/AIDS epidemics. This chapter will now turn to exploring the factors affecting design and implementation of Alternatives-Cameroun's HIV prevention interventions for MSM in Cameroon.

4.1 Factors influencing Intervention Design

For this study, "intervention design" is defined as the substantive content and delivery formats of Alternatives-Cameroun's HIV prevention interventions for MSM in Cameroon. As described previously, the association's Sexual Health and Prevention Unit (SHPU) currently runs four types of intervention, collectively called the "proximity approach to prevention:" bimonthly outreach in bars and cafés; monthly educational workshops at the Access Centre; regular outreach via gay-oriented chat and dating websites; and monthly *grins* (pronounced "gran"), whereby community members host prevention meetings at their homes, targeting their friends. A new strategy is also currently being developed, whereby peer leaders will be trained to independently and informally reach out to the "hidden" MSM in their social networks – bridging the gap between Alternatives-Cameroun and non-self-affirming MSM. In contrast to general population- or community-level outreach, then, the "proximity approach" is characterized by its "closeness" to beneficiaries; MSM are targeted individually or in small groups, in inauspicious settings, and delivered personalized messages. Rather than service delivery "on demand," Alternatives-Cameroun actively brings its services to both "out" and "hidden" MSM.

During all interventions, outreach workers provide information about sexual risk behaviors, protection strategies, HIV/AIDS and other STIs, and medical care options. During all face-to-face outreach, beneficiaries also receive free condoms and packets of water-based lubricant. On the whole, Alternatives-Cameroun's HIV prevention interventions focus heavily on barrier methods for preventing transmission: use of condoms and water-based lubricant during anal intercourse and condom-use during oral sex. Erroneous but popularly-held myths about HIV transmission – for instance, that it cannot be transmitted anally between men – are countered, and the dangers of using oil-based lubricants with latex

condoms are stressed. Furthermore, MSM are encouraged to get tested for HIV and to seek further medical and psychosocial support through Alternatives-Cameroun if they are HIV-positive. Other risk-reduction strategies – including abstinence, fidelity, partner reduction, and treatment of STIs – are presented during interventions, but quite cursorily. The main prevention discourse instead centers on barrier methods during anal and oral intercourse.

Stakeholder interviews and personal observation revealed that these intervention format and content choices were deliberate, based on several factors related to both the Cameroonian and international contexts in which Alternatives-Cameroun functions. The “proximity approach to prevention” is seen as the only way of reaching MSM in Cameroon, many of whom are “hidden.” With this in mind, three factors emerged as having strongly influenced intervention design: stigmatization and criminalization of homosexual conduct; low levels of knowledge and high levels of risk-taking among MSM; and Alternatives-Cameroun’s engagement with the international HIV/AIDS community.

4.1.1 Stigmatization and Criminalization of Homosexual Conduct

Life is hard for MSM in Cameroon. Homosexual conduct is criminalized by Article 347*bis* of the Cameroonian penal code, and individuals suspected of being homosexual are frequently harassed and arrested. In their daily lives, stakeholders described frequently falling victim to ridicule, verbal and physical violence, and social stigmatization. The impact of these two forces on the lives of Cameroonian *nkouandengués*¹³ appears to be the first factor influencing the design of Alternatives-Cameroun’s HIV prevention interventions.

Stakeholder accounts of how homosexuality is popularly perceived largely echoed the existing literature: homosexuality is seen as “un-Cameroonian” or “un-African,” an affront to God and the natural order, grounds for shame and rejection, and a devious means of social or economic ascent:

Many people say that homosexuality is imported, that it’s not Cameroonian, it’s not African. (Stakeholder 1)

[People here] are quite limited by what the Bible says about Sodom and Gomorrah, limited by ancestral African cultures, in which it is said that a man

¹³ *Nkouandengué* is a local term used to describe MSM, not all of whom necessarily identify as gay, homosexual, or bisexual. It serves as a “code name” in everyday life, as the term is not widely known across Cameroonian society.

should only be with a woman; that if a man sleeps with another man, it means he is less than a man. (Stakeholder 8)

Here in Africa, in Cameroon, a homosexual is someone without a purpose, someone who is lost, someone who has ruined his life, someone... completely abnormal, the disgrace of the family. (Stakeholder 4)

Here in Cameroon, it is said that being gay means giving yourself over to the easy life... [it means allowing yourself] to be sodomized for money. (Stakeholder 6)

The impact of stigmatization and criminalization is felt by MSM in their daily lives: most keep their sexuality secret from their family and friends, and many have experienced violence, marginalization, and rejection on mere suspicion of their homosexuality. Effeminate and poor MSM, however, are seen as bearing the heaviest burden; masculine and wealthier MSM, in contrast, are often better able to camouflage their sexuality and thus experience less ostracism due to their sexual orientation:

Men who are not effeminate are luckier because it is not easy to see that he is gay. The ones that have the most problems are those who are effeminate. When you walk down the street, everyone looks at you; they say terrible things to you. (Stakeholder 6)

When you have money, no one says a word to you. You are the master of the family. You can do whatever you want and you will be respected... because you are going to finance your family, your parents and everyone else. You are respected. But when you are gay and you are poor, you become the fool of the family. They insult you all the time. But when you have money, no one opens their mouth. (Stakeholder 4)

Stigmatization and marginalization are thus not passive forces, characterized only by silence and denial. Rather, the topic of homosexuality is quite “out in the open” in Cameroon, and stigmatization and marginalization are active processes reinforced by a number of agents. For one, Article 347*bis* has been enforced with increasingly vigor – and fanfare – in recent years. As one stakeholder commented:

Before [2005], we existed, but I had no idea... I knew [homosexual conduct] was forbidden, but no one knew which article in the code forbid it and what the article said. But now it has become a popular law which everyone can recite. (Stakeholder 3)

Stakeholders resoundingly agreed that, prior to the infamous “2005 Christmas homily” and wave of violence and arrests in 2006, life was easier for MSM in Cameroon. While homosexuality was negatively viewed, it was largely “something unspoken” (*du non-dit*). Stakeholders blame the media, religious and government leaders, and the police for pushing the issue into the public arena, by scapegoating homosexuals for the economic troubles facing Cameroon, promoting negative perceptions of homosexuality, and generally being complicit in homophobic violence and repression:

It used to be like in other countries, you see. What I mean is, we didn't encounter any problems. We were there, there was the general population, when you walked by, maybe you were a little feminine, people would insult you with “queer!” but it wasn't so blatant. What I mean is, it wasn't like it is now, where it's becoming such a huge deal for nothing. You can now find yourself sentenced to a year or six months [in prison]. (Stakeholder 3)

[Before 2005] the atmosphere wasn't like this. [...] No one was attacked, no one burst into people's rooms to pull them out and say to them, you are homosexual, you are going to prison. It didn't happen. (Stakeholder 9)

Before 2005, there were almost no attacks. But after the famous “Top 50” lists, the attacks began. (Stakeholder 11)

Religion forbids and the police punish us, the population punishes us, no one says “stop,” no one says, “No, respect people's private lives.” [...] No one has said “stop,” this is why this is continuing. (Stakeholder 3)

Stigmatization and criminalization are further blamed for the absence of the “MSM issue” from the national HIV/AIDS agenda. To date, HIV/AIDS programming in Cameroon remains “heterocentric,” providing no information about the heightened risk of HIV transmission between men. In a larger sense, stakeholders feel that the public health community in Cameroon is complicit in the exclusion of MSM. Stakeholders explained that many MSM do not reveal their sexual practices to doctors, even during VCT, for fear of stigmatization or denunciation to authorities. In turn, this lack of trust in health professionals frequently produces inaccurate risk assessments and situations unfavorable to health-seeking behavior on the part of MSM, especially as related to HIV/AIDS and other STIs:

I could never tell a doctor whom I do not know, or rather, who is heterosexual and I do not know if he is gay friendly, that I have pain around my anus because someone penetrated me yesterday. There are just some things that I

would not say. There are things that I would keep for myself, and this would distort his diagnosis. (Stakeholder 3)

When a homosexual goes to hospital for an HIV test, and when the doctor realizes he is homosexual, the doctor chastises him, and indirectly the homosexual gets pushed away, denying him the benefit of care and treatment. (Stakeholder 11)

Stakeholders thus feel that stigmatization and criminalization have both environmental and personal impacts, reinforcing a hostile social climate that manifests itself in physical violence, rejection, and marginalization for individual MSM. It is also felt that the line between “homosexual conduct” and “homosexuality” has become increasingly blurred. For instance, none of the MSM arrested under Article 347bis were “caught in the act” (*en flagrant délit*), although this is required by the law. Moreover, men arrested on these charges have encountered great difficulty in finding lawyers to defend them:

[Cameroon] is one of the few countries... where people, out for a drink, get arrested in a bar and the police write “caught in the act of homosexuality” on the arrest notice. [...] ...because you are walking down the street and swaying you hips, you are walking like a woman, or you speak like a woman, and when they arrest you, they write on the arrest notice: “caught in the act of homosexuality.” (Stakeholder 3)

Once you are arrested and “homosexual” is given as the grounds, you no longer have anyone to defend you. (Stakeholder 9)

Stakeholders admit that stigmatization and criminalization keep most MSM “hidden,” making them harder to reach and integrate into the association. Many personally know MSM who do not identify as gay or *nkouandengué*, who maintain concomitant sexual or marital relationships with women and have only infrequent sex with men, and who are fearful of being “outed” by associating with Douala’s “house of the gays,” as Alternatives-Cameroun is increasingly known:

I have friends, you see, who are nkouandengués, but who are executives, managers and such, who say to me, “What the heck are you doing there?” and things like that. Others even say to me, “The fact that you are there, and that you spend time with us, exposes us... creates a situation where people suspect things about us. (Stakeholder 9)

It is difficult [to incorporate “hidden” MSM] because people do not want to be stigmatized. [...] By walking through the door of the Access Centre, if a member of their family or a friend sees them, they are going to say, aha, tell me

who you are walking with and I'll tell you who you are. [...] Look, he is going into the house of the gays, that means that he is gay. (Stakeholder 8)

Even among those MSM who are reached, the effects of stigmatization and criminalization can be felt. For example, it was noted that many MSM willingly take the condoms and lubricant offered by Alternatives-Cameroun, but reject efforts to discuss their sexual practices or identities with peer educators. This behavior was blamed on the shame and fear surrounding homosexuality in Cameroon:

These gays are the kind who do like to speak about their sexuality, you see? You give them a prevention kit [a packet with condoms and lubricant] and that's where it ends... [...] They don't ask you any questions, nothing at all. [...] These gays are really closed off; they are all ashamed to tell you about their health problems. (Stakeholder 6)

With regards to intervention design, it appears that the most important impact of stigmatization and criminalization is on delivery formats: Alternatives-Cameroun cannot sensitize the general population about homosexuality and the “MSM issue,” and cannot reach out to MSM through public media.

It could be possible to reach MSM through generalized prevention messages, but there is one factor that needs to be taken into account: the penalization of homosexuality in Cameroon, which makes many homosexuals reticent to exposing themselves as such. (Stakeholder 1)

The [social] climate in this country prevents us from spreading our message via the general population. What does this mean? With posters, radio announcements, etc. We only had one choice: proximity... going door-to-door, going to homes, finding as many MSM as possible, down in the deepest trenches, to be able to carry out our activities. (Stakeholder 3)

Alternatives-Cameroun thus targets MSM individually or in small groups, through their social networks, in places where they live and meet. In the words of one peer educator, the association strives to be “even closer to them” than is necessary in general-population interventions (Stakeholder 11). Many MSM, victims of stigmatization and criminalization, are unwilling to seek out Alternatives-Cameroun, so the association has instead designed interventions that go to them.

4.1.2 Knowledge Levels and Sexual Practices among MSM

Intervention design at Alternatives-Cameroun is further influenced by stakeholders' awareness that MSM in Cameroon have generally low levels of HIV/AIDS-related knowledge and often engage in risky sexual practices. Interventions are thus designed to fill these gaps in knowledge and promote protective behavior-change among MSM. The stakeholder insights presented here strongly parallel Henry's (2008) empirical findings about sexual risk practices among MSM in Douala. This makes sense, since many of the stakeholders interviewed for this dissertation were heavily involved in recruiting participants and collecting data for Henry's study, and are thus well-aware of its results. While only one stakeholder explicitly cited this experience during his interview, it seems clear that this study's findings have informed stakeholders' understandings of knowledge levels and sexual practices among MSM in Douala.

First, stakeholders explained that many MSM do not know that men can transmit HIV to other men and that UAI is statistically the riskiest sexual practice. Most MSM also lack knowledge of STIs and their impact on HIV transmission. This is largely blamed on the exclusively heterosexual focus of national HIV/AIDS programming:

We recognize that homosexuals and MSM in Cameroon are really ignorant... about everything, ignorant about STIs, ignorant about AIDS, about modes of transmission, how to protect one's self, how to put on a condom, how to use lubricant gel. They don't even know that there is such a thing as lubricant gel! [...] Everything is heterocentric, it is thought that HIV can only be transmitted vaginally and not anally. (Stakeholder 3)

The current prevention campaigns in Cameroon are quite heterocentric, you see a man and a woman, and many gays and nkouandengués say that [these campaigns] do not concern them. (Stakeholder 10)

For their part, popular attitudes towards condom use, fidelity, and partner reduction were viewed as running counter to those promoting prevention and sexual health. Stakeholders reported that MSM, even those who know that condoms can effectively prevent HIV transmission, often do not use them, citing a reduction in sensation during anal intercourse and an unpleasant "roughness" during oral sex (Stakeholder 6). Furthermore, interviewees agreed that many MSM associate condoms with contraception and thus often see no reason to use them for male-male intercourse:

There are those who continue to think that wearing a condom while having sexual relations with a man is a waste of time, because a man cannot conceive. (Stakeholder 3)

I have sometimes heard older gays – someone who has been on the scene for a long time, who has a very... steady sexual life – say that he does not use condoms because he cannot impregnate, he cannot get his boyfriend pregnant. (Stakeholder 10)

Finally, stakeholders agreed that MSM are generally very sexual: “they love having multiple partnerships” (Stakeholder 3). As mentioned in the literature review, this practice is associated with increased risk of HIV infection. For its part, the high prevalence of multiple partnerships was attributed to several characteristics of the MSM “lived experience” in Cameroon. On the one hand, one interviewee expressed that the “hidden” and stigmatized nature of homosexual conduct encourages high levels of partner change among MSM, both with male and female partners:

[Many MSM] try to camouflage themselves. They have a girlfriend or are married, or they have a live-in female partner. On the rare occasions that I see men like this for HIV testing, I have noticed during the pre-test consultation that these men very often have multiple partnerships... either with women, because they do not like women and cannot stand to be with the same woman for a long time, or with men, to avoid being seen often with the same man and inviting suspicion about the nature of their relationship. (Stakeholder 1)

On the other hand, some stakeholders felt that partner change was a fundamental, even natural aspect of male homosexuality, and very common among Cameroonian *nkouandengués*:

The gay male wants to taste everything and is always ready for a change. (Stakeholder 4)

[Many MSM say that] having the same partner everyday is not for them, it would be like eating the same food everyday. (Stakeholder 6)

Finally, the impulse to have multiple partnerships was seen as relating to social norms and familial obligations, especially regarding the role of men in Cameroonian society. Men in Cameroon are expected to get married and produce children. As such, many MSM are eventually forced into marriage – a factor cited as encouraging high levels of partner change in early adulthood:

Very few Africans are really nkouandengués, truly, most of them are bisexuals because society obliges it, the family forces it. Eventually, one simply gives up [being homosexual] and gets married. As such, it is difficult [to tell MSM to have fewer partners], because someone who starts having homosexual sex at age 20, he knows he is going to get married at 30. At 30, his family is going to force that. They are going to fetch a girl from the home village and you are going to marry her. So, he knows that he only has 10 years, and so during those 10 years, he has to have as many one-night stands as possible. (Stakeholder 8)

These attitudes held by MSM are compounded by another factor: the belief that there is no practical reason to limit non-procreative sex. As mentioned previously, dominant definitions of “real sex” across Africa still focus on lineage and reproduction. In turn, MSM associate homosexual intercourse with only fun, pleasure, and escape. This clouds risk-assessment, as both HIV and pregnancy are associated with “real sex,” leading MSM to believe they are avoiding both by having homosexual intercourse. MSM often ask peer educators:

It doesn't produce children; why should it be limited to only one partner? (Stakeholder 11)

[Many MSM] say that making love with guys, there is no risk... [because] your partner cannot get pregnant. (Stakeholder 6)

Stakeholders agree that partner reduction is important for preventing HIV transmission among MSM. However, it is generally felt that its effectiveness as a prevention strategy is both unlikely and unrealistic among Cameroonian *nkouandengués*.

Recognizing that MSM lack sufficient knowledge of HIV/AIDS and engage in risky sexual behaviors, stakeholders have designed prevention interventions to always start from “the basics” about HIV/AIDS, sexual health, and risk reduction. Beneficiaries learn how HIV is transmitted, why UAI is risky, and how oil-based lubricants can compromise condom integrity and increase risk of HIV infection.

When we visit the grins, when we do an educational workshop, we always start with the basics. (Stakeholder 3)

Moreover, a belief in the inevitability of multiple partnerships among MSM has led to interventions that focus heavily on barrier methods for prevention, with only very limited stress put on partner reduction, fidelity, or abstinence:

[During Henry's (2008) study] *we met people who had already had one hundred partners. [...] So it is just not worth it to tell someone to abstain. It is better to say to him, when you want to have a one-night stand, remember to take your condoms and your lubricant.* (Stakeholder 8)

You know, regarding multiple partnerships, we tell people to be faithful to their partners, but at the same time, we know that this is utopian. (Stakeholder 3)

Finally, interventions are not prefabricated, but rather designed to be flexible depending on the audience, with peer educators adjusting content in “real time” around the needs of each beneficiary. It is understood that behavior change is necessary, but cannot be forced, and thus interventions need to be comprehensive, but adaptable:

I adapt my responses to the gaps in each person's knowledge. (Stakeholder 11)

I talk about all these topics, and my approach is to always leave the choice to individuals, to give them as much information as possible, to enable them to make their own choice, because no matter what advice you give, it is always the individual person who is going to choose what is best for himself... because you cannot keep him under surveillance. (Stakeholder 1)

During grins and workshops... each person explains his sexual practices... [and] we try to assess the risks, we try to provide suggestions related to these risks. (Stakeholder 3)

This appears to be a critical aspect in the design of the “proximity approach to prevention”: the ability to personalize interventions around the needs of individuals, rather than spreading general information to an entire population.

4.1.3 International Engagement

While Alternatives-Cameroun's interventions largely reflect its local context, it emerged that intervention design is also influenced by involvement in the international HIV/AIDS community. It was noted that “experience exchanges” with foreign partners have provided ideas for both content and delivery formats. Additionally, a focus on sexual practices, rather than identities, reflects the international public health principles as related to MSM – namely that this population encompasses far more than just self-identified gay or homosexual men, and that targeting identities can exclude “hidden” MSM.

As mentioned, Alternatives-Cameroun has many foreign partners in Europe and North America, but also in Africa. One regional collaborative endeavor that has impacted

significantly on Alternatives-Cameroun's interventions is "Africagay," a network of African NGOs working with MSM in the areas of HIV/AIDS and human rights. Set up by a French AIDS organization, Africagay currently has eighteen members from ten francophone African countries¹⁴, representing a wide range of backgrounds and experiences. Stakeholders overwhelmingly agree that participation in Africagay has enhanced intervention design at Alternatives-Cameroun. "Experience exchanges" with other members have provided ideas for new intervention strategies and strengthened existing practices, as well as offered Alternatives-Cameroun opportunities to capitalize on its own experiences. It was explained, for example, that Internet-based outreach was inspired by work done in Morocco, while the *grins* format originated in Mali:

One time [the SHPU coordinator] was in Bamako, in Mali – it was during an [Africagay] conference that a peer educator from Mali made a presentation, explained [the grins format] – and he found it very interesting and enriching. He came back here and told us this idea, which we found very interesting. [...] You know, in life, all you can do is imitate and copy good things. (Stakeholder 4)

So it's like this, this experience exchange: we said to ourselves, how can we reach the maximum possible number of MSM, of homosexuals, with very few resources? And so this is how we were able to look left and look right, to take the experiences of others and adapt them in our contexts at home. And this is what the others do, as well: they have taken the experiences of others and adapted them to their national contexts, in order to be able to carry out their initiatives. (Stakeholder 3)

The experience exchanges through Africagay have enriched the activities of Alternatives-Cameroun. (Stakeholder 1)

More generally, Alternatives-Cameroun's HIV prevention interventions reflect the international discourse on the "MSM issue": MSM are seen as an inclusive, but highly diverse group of all men who, at any time, for any reason, have sex with other men. For their part, all stakeholders who are members of Alternatives-Cameroun self-identify as gay, homosexual, or *nkouandengué*. Interventions, however, focus largely on sexual practices and risk behaviors, rather than on identities and sexual orientation, in an explicit effort to help the association reach more "hidden" MSM. This is not to say that these issues are ignored in interventions; in contrast, stakeholders felt strongly that LGBT empowerment and liberation are important

¹⁴ Burkina Faso, Burundi, Cameroon, Mali, Morocco, Niger, Côte d'Ivoire, the Democratic Republic of the Congo, Senegal, and Tunisia

objectives of their work. However, this objective is considered secondary: MSM are not explicitly encouraged to “come out” as gay men, but instead to protect themselves and their partners from preventable illness as a matter of public health:

I do not encourage people to “come out,” I do not make that a priority. I only talk about practices: do you have sexual relations with other men? Yes? Ok, let’s talk about your practices. How do you protect yourself? You see, issues having to do with HIV, how you see your future... the practices you have with your partners... I only talk about that. (Stakeholder 3)

Finally, it must be noted that only a small number of stakeholders – in particular, those in the association’s leadership – have contact with Alternatives-Cameroun’s international partners. Nonetheless, the minimal contact which others are beginning to have appears to be influencing intervention design. For instance, one stakeholder closely involved with creating the new “peer leader” outreach strategy, which uses popular MSM to target their “hidden” counterparts, explained how he learned of the “MSM” terminology at a recent meeting with international partners:

I have participated in a conference in Limbé (a coastal town in Cameroon’s Northwest Province) which brought together... people from Sidaction, people from West Africa. [...] This category of person, we spoke about them... These are the people who are not open, for example, it might only happen once or twice a month that he wants to sleep with a man. They are not open about this; they do not consider themselves gay. But this type of person is very hard to reach. So it is up to their friends, those with whom they have sex, to bring them around to accepting themselves. (Stakeholder 4)

Prior to this meeting, this stakeholder – who openly self-identifies as “gay” – had had little personal exposure to multi-sectoral discussions about the “MSM issue” and intervention strategies targeting “hidden” MSM. This meeting thus gave him cause for reflection about the diverse nature of male homosexual relationships in Africa. Exchange between Alternatives-Cameroun and foreign actors thus appears to be influencing how stakeholders think about homosexuals and homosexual conduct, HIV prevention, and strategies for intervention.

4.2 Factors influencing Intervention Implementation

For this study, “intervention implementation” is defined as the “lived experience” of carrying out Alternatives-Cameroun’s HIV prevention interventions in Cameroon, i.e., diffusing the chosen intervention messages via the selected formats. As mentioned in the

previous section, Alternatives-Cameroun employs the “proximity approach to prevention,” whereby MSM are targeted individually or in small groups, in places and situations where they congregate. While some interventions are now done at the Access Centre, it is known that only self-affirming gay or homosexual men frequent the “house of the gays.” In contrast, “hidden” or otherwise reticent MSM can only be reached by bringing interventions to them: in their friends’ homes, in cafés and nightspots, in discrete hook-up locations, or via the Internet. “Going to” MSM, however, brings Alternatives-Cameroun’s peer educators into the public arena, putting them at risk for harassment, violence, and arrest.

The following two sections will highlight the “lived experience” of stakeholders as they implement Alternatives-Cameroun’s HIV prevention interventions among MSM. Through the research process, it became clear that a number of factors have influenced implementation, albeit not in the same ways. For their part, these factors can broadly be grouped into two categories: those having a positive impact on implementation (i.e., make implementation easier, improve the lived experience for outreach workers, help the association reach more MSM, etc.) and those having a negative impact (i.e., present obstacles for implementation, put outreach workers at greater risk, make MSM harder reach, etc.). For purposes of clarity and coherence, these two categories will be discussed individually, each in its own separate section.

4.3 Factors having a Positive Impact on Implementation

Several factors emerged as having a positive impact on implementation of Alternatives-Cameroun’s HIV prevention interventions for MSM in Cameroon. Stakeholders viewed these factors as strengthening their ability to intervene, improving the conditions for intervention, maximizing the association’s reach among MSM, and reinforcing their own willingness to put themselves at risk during outreach. These four factors are: human resources, international connections, local collaboration, and the functioning of the Access Centre.

4.3.1 Human Resources

No matter how strong intervention design may be, translating ideas into practice requires individuals or associations willing and able to act. Human resources are thus a critical factor for intervention in all circumstances. Fortunately for Alternatives-Cameroun, its human resources are widely considered a strong point for the association and its work. In

particular, stakeholders felt that the enthusiasm, dedication, and capabilities of certain key stakeholders have had a strongly positive impact on implementation. Opinions about these individuals were subjective, focusing not just skills sets and professional experiences, but also personality traits and interpersonal abilities that were felt to render these individuals indispensable to Alternatives-Cameroun's prevention approach. As one stakeholder declared:

Human resources are now determining the way we work. (Stakeholder 9)

The first such stakeholder was the SHPU coordinator, who has directed Alternatives-Cameroun's prevention work since the association's creation in 2006. He explained how previous experiences with health outreach had prepared him for the job:

I used to be a member of an HIV/AIDS association. It was youth-focused, and we conducted prevention outreach among young people from the neighborhood. We walked around, we went just about everywhere in the neighborhood handing out condoms, showing how to use condoms, how to put them on, etc. [...] In terms of qualifications, it was perhaps this experience which motivated them to offer me this position. (Stakeholder 3)

Furthermore, many stakeholders praised his devotion, intelligence, and perseverance – qualities viewed as crucial for operating in Cameroon's hostile context. The SHPU coordinator was felt to promote cohesion and discipline among peer educators, and also to motivate them to continue volunteering in a context of poverty, stigmatization, and violence. Foreign partners also expressed great confidence in him, seeing him as an important force for further development of the association. By and large, stakeholders attributed much of Alternatives-Cameroun's success in implementing its HIV prevention interventions to the SHPU coordinator:

I think that the health unit found someone who is very committed and who learns quickly, and who wants to learn, as well. (Stakeholder 9)

[He is] one person whom I greatly appreciate... [...] He works a lot, he is really devoted, and he works very hard. (Stakeholder 5)

[During a recent prevention and outreach campaign outside of Douala,] the SHPU coordinator frequently sent me emails to give me advice, to motivate me, to find out what I was doing, and how I was doing. (Stakeholder 11)

The association's president drew similar praise for his dual role as chief fundraiser and resident physician. He was felt to impact positively on implementation in both direct and

indirect ways. On the one hand, he is seen as keeping the whole association running, especially with regards to funding for HIV prevention. Stakeholders seem to agree that this work, involving close relations with foreign donors and careful management at home, requires a particular commitment that not every member can offer. As stakeholders commented:

He is someone who is devoted heart, body, and soul to what he does. [...] He gives everything for the association. [...] To be frank, at the present time, I do not see anyone else in the association, myself included, who could do [this] work. [...] He is someone who has real vision. (Stakeholder 9)

We are lucky to have a president who is a fighter, [because] you know, a fight like ours is not easy... (Stakeholder 4)

On the other hand, the president is felt to indirectly strengthen implementation of prevention activities by reinforcing the association's provision of care and treatment for MSM. As mentioned earlier, MSM often have negative experiences with healthcare professionals in Cameroon. By providing a safe space in which MSM can openly discuss their practices and concerns, the president is seen as creating an environment which encourages health-seeking behavior among MSM:

First of all, the people who ask me questions are friends of mine, who come to me, who tell me, you are in that association, you know things... I have some pain, I hurt in this particular area, I have these symptoms, can you help me with this? And what can I do? So, I try to speak with them a bit, I try to understand a bit what he is suffering from, and then I say, hey, the only advice I can give is to come see our doctor. He can help you out with this. (Stakeholder 6)

Finally, the SHPU's four peer educators also represent an important strength for implementation. As mentioned, the "proximity approach to prevention" requires the association to have direct access to MSM, in places where they live and congregate. Through the research process, it was revealed that peer educators are "closer" to the MSM community, in terms of their social circles and habits, than the president or SHPU coordinator and thus function as important conduits between the association and especially "hidden" MSM. For instance, peer educators explained their central roles in finding gay-oriented nightspots and setting up *grins*:

Each peer educator tells the coordinator... For example, me, I gave him the locations that I know, that I myself always frequent. I know of several places

where one can find gays, and so I go to see my coordinator, I say, hey, there's a place where we can find gays, I would like to start going there [to conduct prevention outreach]. (Stakeholder 6)

I have some friends in my neighborhood... I went to see them, I realized that this one friend, along with other friends who were with him – sometimes there were up to 10 of them – they never visited the association, and they were people who did not know much about condoms, about lubricants. This is the reason why I went to see [the coordinator], I spoke with this particular friend, and today this is one of the biggest grins which we run. (Stakeholder 4)

The courage and dedication of these peer educators must also be mentioned, for these characteristics emerged as vital for implementation. An anecdote can best illustrate this. On one Saturday evening, the researcher participated in a prevention intervention at a place called “Chez Koloko,” a gay-oriented bar in downtown Douala. Upon arrival, it was discovered that the police had forced the bar’s patrons onto the street, before proceeding to detain some of them. Despite some initial hesitation, peer educators decided to intervene anyways: they discretely circulated among the crowd, distributing condoms, lubricant, and contact information for Alternatives-Cameroun. Before long, the police took notice and chased the researcher and peer educators down an alley, where the group encountered local bandits who attempted to attack and rob them. Fleeing back up the alley, the group then encountered the police once more. It was only by running in a third direction and immediately catching a taxi that the group avoided further harassment. On inquiry, peer educators agreed this was a frequent occurrence, even citing several instances of assault and blackmail during outreach. It became clear in this instance that Alternatives-Cameroun’s “proximity approach to prevention” requires significant risk-taking on the part of peer educators. Without their courage and dedication, it is doubtful that this approach could continue to be implemented.

Each person sacrifices something [for this cause], everyone puts his life in danger. Look at me, I could be arrested right here [in this bar in Yaoundé], just like they can be arrested over there [at the Access Centre]. Each person puts his life in danger, but it is together that we are strong. (Stakeholder 5)

4.3.2 International Connections

The second factor having a positive impact on implementation of Alternatives-Cameroun’s HIV prevention interventions for MSM is international connections. Within the association’s hostile and resource-poor context, these partnerships provide the necessary

means for implementation: money, materials, credibility, and security. Stakeholders generally feel that these resources have allowed Alternatives-Cameroun to go to scale with its initiatives, while simultaneously buffering itself against repression from the police.

First, stakeholders described how international connections have enabled Alternatives-Cameroun to acquire a measure of financial and material security, not just for individual initiatives, but also for the long-term functioning of the association. For example, the Access Centre, opened in 2008 with funding from Sidaction, provided the previously itinerant association with an administrative headquarters and a place to receive MSM for prevention, care, and treatment. This longer-term perspective is seen as a positive force for implementation, since it affords stability for Alternatives-Cameroun and sustainability for its HIV prevention activities:

[Our foreign partners] play a number of roles here because it is they who finance us, it is they who finance the Centre, and who finance everything in the Centre. (Stakeholder 6)

We have the advantage, the luck... to be able to really function, to have found funding which enables us to set up activities that we can run on a daily basis, that we want to run, and not once-off activities that depend on the presence or absence of funding. (Stakeholder 1)

First of all, the Sidaction-AIDES-Ministry of Foreign Affairs project¹⁵ is four years, until 2012. After that, I think it will continue; it's not going to end in 2012. Even if the Ministry of Foreign Affairs no longer funds it, the partnership with AIDES, with Sidaction is going to continue. From my perspective, I see something lasting in all that. (Stakeholder 3)

Besides money, international connections also provide material security that greatly facilitates implementation. As mentioned previously, Alternatives-Cameroun's HIV prevention interventions focus largely on barrier methods during anal and oral intercourse, the success of which depends on MSM having regular and reliable access to condoms and water-based lubricant. At the time of the association's founding, this was a critical issue: stakeholders described "hanging on the lips of our international friends," waiting for news of a visit to Douala in order to request a supply of lubricant (Stakeholder 3). Since then,

¹⁵ This joint program, named the "Programme MSM," is funded by the French Ministry of Foreign Affairs and coordinated logistically and administratively by two French NGOs: Sidaction and AIDES. Targeting roughly ten MSM-oriented NGOs in West and Central Africa, this program seeks to build the capacities of these organizations to design, implement, and evaluate HIV prevention, care, and treatment interventions for MSM. This is the first MSM-focused HIV/AIDS program in Africa funded by the French government.

however, commitments from foreign partners and increased opportunities for stakeholders to travel abroad – for example, to the Mexico City conference or Africagay meetings – have largely solved this problem:

Whenever we would go for conferences... in our suitcases... we would take out all our things and put packets of lubricant in the bottom, and then put our clothes back on top. (Stakeholder 3)

Within the Africagay network, we now no longer have to worry about his problem, because during our first collaborative workshop, which was held in Ouagadougou, I really stressed this matter – the supply of lubricating gel – when I introduced Alternatives-Cameroun. We had serious problems regarding the supply of lubricant... [...] Within Africagay we have been fortunate: AIDES has promised us, or maybe they have already sent it – Alternatives will soon have 35,000 packets of lubricant... This will be a big relief for us. [Moreover,] if we now include in our projects that we want to purchase lubricant, it will be funded. (Stakeholder 3)

Condoms and lubricant, that's the gay man's weapon. [...] It's a necessity. For the moment, I don't think we have a [supply] problem. [...] I think this matter is now taken care of, because before, whenever we visited the grins, we only left two packets of lubricant. Now we leave six to eight... per person. (Stakeholder 4)

Finally, stakeholders expressed that Alternatives-Cameroun's international partnerships provide the credibility and security necessary for implementing interventions for among MSM in the hostile Cameroonian context. As has been discussed, the “MSM issue” – and a focus on “vulnerable populations” more generally – is now firmly on the international HIV/AIDS agenda. However, MSM are still absent from national programming in Cameroon, a fact complicated by pervasive stigmatization, repression, and violence against MSM. In such a context, stakeholders feel that international partnerships provide not just moral, but also legal and epidemiological justification for their work. A sentiment exists that, should Alternatives-Cameroun encounter trouble, its international partners would come to its defense:

The fact that we are known internationally and that we have the support of certain international organizations and certain diplomatic missions in Cameroon gives us some credibility. (Stakeholder 1)

The international community would not look kindly [on Cameroon] if it arrested activists or people who carry out prevention activities targeting vulnerable populations. (Stakeholder 3)

4.3.3 Local Collaboration

Two local partnerships also impact positively on implementation of Alternatives-Cameroun's HIV prevention interventions for MSM. The first is with a local clinic – the “Integration Clinic” – which provides anonymous VCT, care, and treatment services for MSM unwilling to visit the Access Centre. The other is with owners of gay-friendly bars and cafés in Douala, which offer Alternatives-Cameroun regular and reliable access to large segments of the *nkouandengué* community.

As mentioned previously, stigmatization and criminalization keep many Cameroonian MSM “hidden.” As a result, the “proximity approach to prevention” was developed in order to discretely locate and reach these men, often through their social networks, in places where they congregate. An important component of these interventions is knowledge-building, especially about condoms and lubricants, but also about HIV testing, STIs, and medical care options for MSM. However, negative experiences in healthcare settings often keep MSM quiet about their symptoms and sexual practices; at the same time, fear of exposure keeps many MSM away from the Access Centre.

A key solution to this problem has been a partnership with a local clinic, called the Integration Clinic. Alternatives-Cameroun's attending physician consults here in the mornings, before coming to the Access Centre in the afternoons. At the Integration Clinic, MSM can meet with a gay-friendly doctor in complete anonymity: it has no geographic or visible connection to the Access Centre, and is also open to the general public. Stakeholders feel that this partnership facilitates implementation by providing MSM with more options for care, and thus increasing the likelihood that they will seek prevention-promoting healthcare, such as HIV testing and STI screening:

It is understood that any person who walks through the door of the association, who makes it as far as the Centre, is a person who... at least someone who accepts his identity or his homosexuality. (Stakeholder 1)

Whenever I do prevention outreach, I tell people, if you do not want to come to the Centre, because you are afraid of being catalogued as a homosexual, you can always go to our partner clinic, the Integration Clinic... It is open to everyone; no one will know you are gay. (Stakeholder 3)

There are some who do not want to be seen, you know? People know that when someone comes to see the doctor [at the Access Centre], it means he might be HIV-positive... and that bothers people a bit. Maybe you come here, someone says to you, look, this guy over here, he is sick. They are going to gossip a bit... So these people prefer to be a bit more discrete, they prefer to go to the Integration Clinic. (Stakeholder 6)

The second local partnerships that assist with implementation involve collaboration with managers of gay-oriented nightspots in Douala. Stakeholders described these relationships as paramount: they provide crucial access to large segments of the *nkouandengué* community which do not participate in other interventions. It must be noted that these partnerships are fragile. During the research visit, for instance, the owner of “Chez Koloko” was brutally attacked and killed – under unknown, but suspicious circumstances. The subsequent closing of his bar has cut Alternatives-Cameroun off from many beneficiaries, undermining further implementation of HIV prevention interventions. These partnerships are also dependent on the willingness of bar owners to host Alternatives-Cameroun – something not to be taken for granted. For example, no prevention outreach was conducted in September 2007 due to conflicts with one such partner. Staying on good terms with bar and nightspot owners is therefore clearly an important factor for implementation.

One nascent local collaborative opportunity is also worth mentioning. In late November 2008, Alternatives-Cameroun participated in a two-week traveling HIV prevention and testing campaign in the south of Cameroon, along with six other national NGOs. This was Alternatives-Cameroun’s first major outreach event outside of Douala. The one stakeholder involved in this campaign described the other participant organizations as unaware, but still open and supportive of Alternatives-Cameroun’s work. He further explained how this opportunity enabled him to counteract negative stereotypes about homosexuals held by these associations, and also, for the first time, to spread Alternatives-Cameroun’s message and contact information to MSM in southern Cameroon:

[I had no bad experiences,] quite on the contrary. Whenever I had a free moment, they would always come and say to me, well, how do you do your work? What are [gays] like? Are they not afraid? How do they live? Those who are HIV-positive, do they receive care and treatment? In other words, everyone wanted to know how we operate. (Stakeholder 11)

[When I told them I am homosexual,] they were shocked... [...] They said, you are gay? But you are not effeminate; we do not see you with boys all the time. I

told them, being gay does not always mean being effeminate. It does not mean always having boys around you. (Stakeholder 11)

The main difficulty [I faced] was related to the fact that I had trouble meeting MSM in the different cities we visited. But using the advice given to me [by the other associations], I was able to find some. [...Advice] to speak in more concrete terms about my own sexuality if people wanted to know about it. And in speaking about my sexuality, I think I was able to find about a dozen [MSM]. (Stakeholder 11)

While the overall impact of this new local collaboration has yet to be felt, it seems clear that such opportunities can help Alternatives-Cameroun implement its interventions by providing increased access to MSM, both directly and through referrals from other NGOs.

4.3.4 The Access Centre

Despite the fact that “hidden” MSM are usually unwilling to frequent it, the Access Centre is nonetheless considered by stakeholders to be a factor impacting positively on implementation. This was attributed largely to the Centre’s triple function – as a healthcare facility, administrative headquarters, and *nkouandengué* community hub – which fosters community cohesiveness and regular exchange between stakeholders and beneficiaries. Located on Douala’s main boulevard, yet set back and accessible via a discrete courtyard, the physical space was chosen for its particular mix of public and private, and for its proximity to major transport intersections. As stakeholders explained:

We are fortunate to have a center... where gays can go, a center where gays can see a doctor when they are sick, a center where gays can go when they are in distress... gays who have been rejected by their families, a center to which everyone can come. (Stakeholder 4)

That location can be public and private at the same time, you see? Public, because everyone is able to access it, but once you are inside, you are at home. No one can come to spy on you, ‘What is he doing?’ and so on and so forth. [...] One cannot see it from the street, you see, ‘What is in there? What is going on?’ One can live very well inside there without being seen from the road, and when someone leaves, he can find transport and return home, without having any problems. (Stakeholder 9)

The impact of the Access Centre on implementation can be felt in three ways. First, computers and reliable Internet access are available, facilitating the critical Internet-based component of the “proximity approach to prevention.” Most stakeholders lack this equipment

at home, as well as the funds necessary to frequent Internet cafés. Second, relatively large-scale prevention interventions can be held at the Access Centre. At the end of the research visit, for example, a day-long event was organized to commemorate World AIDS Day (1 December), attended by upwards of thirty MSM. Stakeholders and participants alike admitted that, in Cameroon's hostile context, interventions of this scale would attract too much attention if held elsewhere. Finally, the new "peer leader" prevention strategy described earlier expands the number of active outreach workers beyond the inner circle of the SHPU. Stakeholders felt that having the Access Centre facilitates the integration of these "peer leaders" in the association by providing them with meeting space, regular contact with SHPU peer educators, and steady access to condoms and lubricant for distribution. In these ways, the Access Centre appears to play an important, positive role in the implementation of Alternatives-Cameroun's HIV prevention interventions.

4.4 Factors having a Negative Impact on Implementation

Through stakeholder interviews and personal observation, it also became clear that some factors have a negative impact on implementation, in that they undermine the ability to intervene among MSM, weaken personal motivations to get involved, and undercut access to especially "hidden" MSM. These three factors are: violence and harassment in the context of stigmatization and criminalization; the public behaviors of some MSM; and "volunteer fatigue" in a resource-poor setting.

4.4.1 Violence and Harassment

Given the climate of stigmatization and criminalization of homosexual conduct in Cameroon, it is perhaps not surprising that violence and harassment against Alternatives-Cameroun's outreach workers emerged as a major factor having a negative impact on implementation. One thing is surprising, however: this repression comes not just from police, bandits, and other non-MSM, but also from MSM beneficiaries themselves – men who sleep with other men, but do not openly admit to it, even to Alternatives-Cameroun's outreach workers. This creates an environment in which peer educators put themselves at significant risk when carrying out interventions.

First and foremost, repression from authorities, vandals, and society at-large is seen as a direct result of stigmatization and criminalization, which stakeholders feel legitimizes violence against MSM, while simultaneously denying MSM the right to legal recourse. The

impact on implementation is two-fold: not only are beneficiaries scared off and thus unable to profit from outreach, but peer educators are as well, leaving them foiled and frustrated. As stakeholders explained:

We always meet people who hassle us, people who attack us... [...] These street vandals who know we are gay and that we have come to do prevention outreach. Sometimes the police, as well, during the grins, the police will come and hassle us, then the gays all run away... It's very discouraging. (Stakeholder 6)

Let me remind you about last Saturday when we went to do prevention outreach [at "Chez Koloko"], we were caught on both sides: we had the police on one side, vandals on the other side. [...] This does not allow us to work well, to better carry out our activities. (Stakeholder 3)

Stakeholders agree that Article 347bis sits at the heart of the problem and are united around fighting for decriminalization of homosexual conduct. However, there is a strong sense that repealing this law will not necessarily reduce violence and repression or improve the conditions under which Alternatives-Cameroun works. Stakeholders believe the "lived experience" of MSM in Cameroon will change little, even if public authorities are no longer legally able to charge MSM with the crime of homosexuality. As such, stigmatization and repression related to this law are likely to influence implementation efforts in the foreseeable future:

But how can we carry out prevention interventions with a law that... I mean, how can we effectively intervene in the area of public health with a law hanging over our heads? [...] This law, it must go! (Stakeholder 3)

Repealing this law will at least remove the arguments put forth by officials, who often say that homosexuality is illegal in Cameroon, and therefore, intervening among homosexuals means you are putting yourself in danger with regards to the law. [...] If Article 347bis is repealed, at least with regards to the police, we will have fewer problems... We hope. (Stakeholder 1)

But for the association itself, depenalization will not bring about any big changes. Why? Because depenalization will not have any influence on the "lived experience" of [MSM] within this culture. (Stakeholder 9)

Somewhat more frustrating for stakeholders, peer educators at times encounter aggression and harassment from MSM themselves. For example, Alternatives-Cameroun conducts prevention outreach in a place called *le lac*, where young MSM are known to

congregate in search of sexual encounters. It has been noted that many MSM who frequent this area are “particularly vulnerable, [living] in precarious circumstances in which they are unable to purchase condoms and which sometimes lead them to prostitution” (Alternatives-Cameroun 2007). Where the need for prevention is greatest, however, outreach workers encounter the most difficulty. The SHPU coordinator, for one, once had to pay off several MSM aggressors at *le lac* – aggressors who then demanded the condoms and lubricant he was distributing. Another stakeholder confirmed having had similar experiences:

Whenever we go to le lac, we usually get assaulted by gays. [...] I do not know why, but... whenever we are there, they pretend they are heterosexuals. They push us to leave, and then they come back and hit on the guys who accepted our prevention outreach (i.e., took the condoms and lubricant). (Stakeholder 11)

This is problematic for implementation: interventions are designed to reach especially vulnerable, “hidden” MSM, but violence from this population prevents effective outreach. Stakeholders thus put themselves at significant personal risk by carrying out Alternatives-Cameroun’s HIV prevention interventions for MSM.

4.4.2 Public Behaviors of some MSM

More generally, stakeholders felt that the public behaviors and actions of some MSM impact negatively on implementation of HIV prevention interventions. During outreach – and especially in gay-oriented nightspots – stakeholders often encounter MSM who dress flamboyantly and engage in open displays of affection, often in plain sight of neighbors and police. While stakeholders may personally sympathize with the desire of these MSM to live freely, most nonetheless see the blatant challenging of public sensibilities as counterproductive for implementation. For instance, stakeholders explained after the ill-fated prevention activity at “Chez Koloko” that it was a small group of effeminately-dressed MSM that had initially drawn the police to the scene. Stakeholders explained that they frequently caution MSM not to provoke public outrage with their behaviors:

How can you expect to be given rights when you show those in power, look, when you give me these rights, I am going to shock you? (Stakeholder 3)

At present, however, this appears to remain an obstacle to implementation. Stakeholders expressed exasperation that behaviors of a small number of MSM often undermine their actions:

Not everyone is aware of what we go through, not everyone is conscious of what we have to endure. I saw [Koloko's] distress, I saw the anger, the sadness [when he] complained to me about the attitudes of these MSM, these homosexuals. I understand him. You can understand that it is discouraging. We really want to help the homosexual, the nkouandengué community to be able to emancipate itself, but at the same time... those on the receiving end of our interventions do not always encourage us with actions, with attitudes... which are equally responsible, with behaviors that are equally responsible. (Stakeholder 3)

At the Centre, but also during prevention interventions... every time... any progress we make is undermined a little by people who act out like this a bit too much, you see. (Stakeholder 5)

This matter appears to be increasingly impacting on the motivations of outreach workers. To summarize the irritation of one association member (not interviewed), voiced during a “cool down” session following the intervention at “Chez Koloko”: why should I risk my personal safety to distribute condoms and lubricant to people who ignore my advice about flashy public behavior?

4.4.3 “Volunteer Fatigue”

The final factor impacting negatively on intervention implementation – “volunteer fatigue” – reflects the combined effects of psychological, emotional, and financial strain on Alternatives-Cameroun’s peer educators. Despite its relative financial security, Alternatives-Cameroun remains highly dependent on volunteers for implementing its HIV prevention interventions. At present, only the SHPU coordinator receives a small stipend for his engagement, while peer educators and “leaders” work as *bénévoles*. Implementing the “proximity approach to prevention” is not cost-free, however: for *grins* and nightspot-based interventions, peer educators must often travel by taxi to remote parts of Douala, staying out past midnight to visit several locations. As of December 2008, these costs were born solely by peer educators – even in cases of bribery or robbery. While stakeholders understood that a strong *principe du bénévolat* (principle of volunteerism) was critical for associations working in resource-poor settings, there is a sense that “volunteer fatigue” could have a negative impact on implementation. Put bluntly:

Too much volunteer work kills volunteerism. (Stakeholder 3)

Volunteerism cannot be a full-time job. (Stakeholder 9)

Besides the hardships of violence and repression cited previously, stakeholders were in agreement that volunteerism cannot continue indefinitely in a context of poverty, such as in Cameroon. Many stakeholders are un- or underemployed, and several bear heavy financial responsibilities towards their families or debts from their studies. Stakeholders joined Alternatives-Cameroun out of a desire to fight for gay rights and increased access for MSM to HIV prevention, care, and treatment. Over time, however, many feel that “volunteer fatigue” will take its toll on implementation by undermining the association’s ability to retain experienced outreach workers:

We cannot work eternally as volunteers – we do not want to work eternally as volunteers – because each and every one of us has his financial responsibilities. School needs to be paid for, rent needs to be paid. [...] And we [volunteers], we risk our lives every night when we go do prevention outreach. When we go to nightspots, we start at midnight, one o’clock in the morning. You know... we risk being attacked, as you saw yourself at ‘Chez Koloko’... And when we go to le lac, for example, we get attacked too, and we have to pay off our attackers to be able to do our prevention work... [and the money] comes out of our pockets, not the pockets of Alternatives. (Stakeholder 11)

People need to be motivated a little. What does that mean? Sometimes we do prevention outreach very, very far away from here. The association should at least pay for people’s transport. It’s true that someone who has to pay for his own transport all the time... at some point, he is going to get tired of that. (Stakeholder 4)

Volunteerism is great, but it certainly has limits, because... people live in a context here where they have no work, but they have needs. As such, if we do not sufficiently provide for these needs, we will not be able to hold onto them for very long. (Stakeholder 1)

This is a source of tension within the association. On the one hand, peer educators are increasingly expressing their need at least for transport stipends and per diems during interventions, and at best for salaries. It is felt that “little motivations” will go a long way towards retaining volunteers:

People are getting tired because they have been implementing interventions for two years without a single indemnity, and without any salary. It is not salaries that they want, really, it is just small indemnities for transport, little motivations so that they will be able to be more effective during interventions. (Stakeholder 3)

I would like to receive a salary because you know... I think... when someone goes from point A to point B, and when you have a little motivation, it really reinforces your passion for your work. (Stakeholder 8)

At the same time, it is not clear that Alternatives-Cameroun – which is presently dependent on foreign funding – will be able to secure sufficient funding to cover these needs. As one stakeholder explained:

We will never be able to guarantee salaries, because we depend completely on financing which comes from abroad; we do not yet have our own resources. (Stakeholder 1)

“Volunteer fatigue” thus presents a challenge for Alternatives-Cameroun. It is clear that, at present, the association needs willing and available volunteers to implement its “proximity approach to prevention.” However, the “lived experience” for these volunteers – with the ever-present threat of physical violence and harassment, and a relatively heavy financial burden – is increasingly unpleasant, potentially undermining their motivations for continued involvement with implementation and outreach.

4.5 Summary

This chapter summarized the major findings of the field research conducted in Cameroon. Based on interviews with key stakeholders and personal observation of Alternatives-Cameroun’s activities, it has become clear that a number of factors have influenced the design and implementation of the association’s HIV prevention interventions for MSM.

Intervention design, for its part, was found to be influenced by two factors related to the Cameroonian context – stigmatization and criminalization of homosexual conduct, and low levels of knowledge and high levels of risk-taking among MSM – and one factor related to the global context of HIV/AIDS programming responding to the “MSM issue” – Alternatives-Cameroun’s connections with international partners. The factors reflect both stakeholder experiences and empirical evidence about MSM in Douala. On the one hand, research has shown that MSM in Cameroon and across Africa frequently are “hidden,” have multiple concurrent sexual partnerships with both men and women, and inconsistently use condoms and water-based lubricant (Henry 2008; see also Larmarange 2008; Wade *et al.* 2005). Intervention design incorporates and responds to this evidence. On the other hand, no

studies have shown how to find and reach “hidden” MSM in the Cameroonian context. Instead, interventions have drawn on the innovative, but un-researched experiences and unverified methods of other NGOs across Africa. What is clear is that Alternatives-Cameroun’s interventions have been designed by Cameroonian MSM, for Cameroonian MSM, in an attempt to address the specific epidemiological, social, legal, and health-related problems encountered by this population.

The factors affecting intervention implementation, on the other hand, were found to belong to two broad categories: factors having a positive impact, and those having negative outcomes. By and large, positive factors were related to Alternatives-Cameroun itself, as well as to its various local and foreign partnerships. Negative factors, in contrast, reflect the context in which Cameroonian MSM live and Alternatives-Cameroun functions: a resource-poor setting characterized by stigmatization and criminalization of homosexual conduct – and all-to-frequent violence against both suspected and “out” MSM. The challenge of implementation becomes apparent here. The positive factors, for their part, are contingent on the ability and willingness of individuals to mobilize and build alliances around the “MSM issue” within a hostile context. Alternatives-Cameroun seems to have been lucky in this area, led by a handful of competent and eager stakeholders who have obtained financial and moral support from critical partners in Cameroon and abroad. That being said, it is questionable whether Alternatives-Cameroun could continue on its current trajectory in the absence of these stakeholders or partners. The reason for this lies with the negative factors, which are highly contextual and thus largely out of Alternatives-Cameroun’s control. Given the physical, emotional, and financial burdens of intervening among MSM in Cameroon, it is not unreasonable to wonder if, over time, the negative factors may erode both the capacity and the willingness of stakeholders to continue their engagement with Alternatives-Cameroun. The future of Alternatives-Cameroun’s HIV prevention interventions for MSM clearly rests on the association’s ability to reinforce the positive factors, while continuing to deflect the negative.

Chapter 5: CONCLUSION

Recently, the “MSM issue” in sub-Saharan Africa has truly come to the fore. The XVII International AIDS Conference held in Mexico City in August 2008 showcased no fewer than eight oral presentations and twenty posters about MSM and HIV/AIDS in Africa, and even included a “Global Forum on MSM & HIV” on the pre-conference agenda (Broqua 2008a). In November, the 2008 ICASA meeting in Dakar brought this discussion to Africa itself, featuring an emphatic closing address by the president of Alternatives-Cameroun – “the first time... an openly gay man has been an invited speaker at any major official African forum” (IGLHRC 2009b). Epidemiological data continues to accumulate about the position of MSM within Africa’s “heterosexual” HIV/AIDS epidemics, and at least one study has already shown the positive impact which targeted HIV prevention interventions can have on the sexual practices of African MSM (Wade *et al.* 2008). As Broqua (2008a) declares in his summary of the Mexico City conference: “the silence has finally been broken.”

Yet all is not well in the land of Indomitable Lions, nor in most of the rest of sub-Saharan Africa. On 5 May 2009, Alternatives-Cameroun announced the assault and arrest of another suspected MSM in Douala (IGLHRC 2009a). The situations in Senegal and Burundi are equally disheartening. Shortly after the 9 Senegalese men arrested on charges of homosexuality were released from prison, local Imams declared jihad against all homosexuals in this majority-Muslim country (Karl 2009). Around the same time, Burundi outlawed homosexual conduct between consenting adults (AI 2009). Activists and policy-makers are also feeling the heat: at the most recent Africagay consortium, held in April 2009 in Bamako, national police forces confiscated materials and threatened to shut down the event (Sidaction – personal communication). So while the silence may now be broken, there is little indication that African leaders and societies are eager to listen.

5.1 Summary of Results

The need for effective and accessible HIV prevention among African MSM is more necessary than ever. To that end, local NGOs and civil society actors are urgently needed to launch interventions that will successfully reach and promote behavior-change among MSM, without putting them at risk for stigmatization, violence, or arrest. How they will accomplish this, however, remains an open question. As a first step towards a response, this dissertation

explored the factors affecting design and implementation of Alternatives-Cameroun's HIV prevention interventions for MSM in Cameroon. It demonstrated that local, regional, and global factors have all impacted on the association's strategies for intervening among MSM in Douala – and that factors related especially to the Cameroonian context have presented obstacles with which the association must continue to grapple.

Three factors were found to impact on intervention design: stigmatization and criminalization of homosexual conduct; low knowledge levels and high levels of risk-taking among MSM; and international partnerships. Stakeholders explained that, in Cameroon, homosexuality is considered un-African, unnatural, and shameful, and homosexuals are believed to sleep with each other for political or economic gain. Additionally, homosexual conduct is criminalized by Article 347*bis* of the Cameroonian penal code, leading to many cases of arrest and detention. This stigmatization and criminalization has kept the “MSM issue” off the national HIV/AIDS agenda, and MSM live in fear of violence, arrest, and rejection. This, in turn, keeps many MSM “hidden” and unwilling to discuss their sexual practices or problems with medical professionals. Alternatives-Cameroun's HIV prevention strategies – collectively called the “proximity approach to prevention” – have thus been designed to reach MSM where they live and congregate, in settings where they can feel free and safe.

Stakeholders also described low knowledge levels and high levels of sexual risk-taking among MSM in Cameroon. Specifically, many MSM are unaware that HIV can be transmitted anally and that using condoms and water-based lubricant can significantly decrease both partners' risk of infection. Furthermore, MSM are known to frequently engage in multiple partnerships with both men and women – a fact supported by Henry's (2008) study of MSM in Douala. However, stakeholders feel that cultural and social factors render partner reduction an unrealistic prevention strategy in the Cameroonian context. As such, interventions are designed to provide basic knowledge about HIV/AIDS, STIs, and risk behaviors, and focus primarily on barrier methods – condom-use with water-based lubricant – for preventing HIV transmission. Interventions are also designed to be flexible, adapted to the needs of individual beneficiaries, on the understanding that knowledge levels vary highly among MSM.

Lastly, stakeholders expressed that engagement with international partners, such as “experience exchanges” with like-minded African associations, has greatly influenced the

“proximity approach to prevention.” For example, the *grins* format and Internet-based outreach were inspired by interventions conducted in Mali and Morocco, respectively. Moreover, the international public health discourse on MSM – namely, that this group encompasses more than just self-affirming gay or homosexual men – appears to have encouraged the association’s focus on sexual practices and risk behaviors, rather than identities and orientations, during interventions. This means that MSM are not encouraged to “come out” as gay, but rather to protect themselves and their partners from preventable illness as a matter of public health.

In short, HIV prevention intervention design at Alternatives-Cameroun incorporates stakeholder experiences in, and understandings of, the local Cameroonian context, as well as empirical data about MSM risk behaviors in Cameroon and internationally-accepted principles for outreach among MSM. The addition of a new “peer leader” strategy indicates further that intervention design is an on-going process at Alternatives-Cameroun, building on information acquired in both local and international contexts. What is clear is that Alternatives-Cameroun’s interventions are designed by Cameroonian MSM, for Cameroonian MSM, in response to local realities.

Intervention implementation – the “lived experience” of translating design into practice – is a similarly on-going process. In Cameroon’s hostile and resource-poor context, outreach workers risk their physical safety and bear significant financial burdens in intervening among MSM. Implementation thus poses a continual challenge for Alternatives-Cameroun. That being said, some factors help the association bolster itself against adversity. Factors impacting on implementation thus belong to two broad categories: those having a positive impact and those having negative outcomes on the “lived experience” of intervening among MSM in Cameroon.

Positive factors include existing human resources, local and international partnerships, and the recently-opened Access Centre. Certain key stakeholders – the coordinator of the SHPU and the association’s president, in particular – were widely viewed as indispensable for implementation, since they offer strong, capable leadership and ensure the association has sufficient financial and material resources for intervention. The current peer educators were also seen positively, both for their courage and for their roles as conduits between the association and especially “hidden” MSM groupings.

International partnerships were recognized as providing the funds, materials, credibility, and security necessary for Alternatives-Cameroun to operate in its hostile and resource-poor context. Stakeholders noted especially that international partners had enabled Alternatives-Cameroun to secure reliable stocks of water-based lubricant. Local collaboration, with the Integration Clinic and nightspot owners, was seen as further facilitating implementation in two ways. First, the Integration Clinic offers “hidden” MSM access to a gay-friendly doctor, in a setting more private than the Access Centre. This is felt to increase the association’s reach among MSM hesitant to frequent Douala’s “house of the gays.” Second, gay-friendly nightspots provide Alternatives-Cameroun with regular access to substantial segments of the *nkouandengué* community, and thus with opportunities to spread Alternatives-Cameroun’s prevention messages.

Finally, the Access Centre was cited as strengthening implementation by fostering community cohesiveness and exchange between stakeholders and beneficiaries, as well as by providing a stable, secure location in which to organize larger-scale interventions and conduct Internet-based outreach. All in all, stakeholders felt that Alternatives-Cameroun’s accumulated human, material, and relational capital have equipped the association to implement its HIV prevention strategies among MSM in Cameroon.

In contrast, the factors found to impact negatively on implementation largely reflect the hostile and resource-poor context in which Alternatives-Cameroun operates. First, both stakeholders and beneficiaries face the omnipresent threat of violence and harassment, not just from police and bandits, but also from MSM themselves. This is particularly traumatic for stakeholders, who are sometimes assaulted and robbed by the MSM to whom they have just given condoms and lubricant. Aggression aside, some MSM also behave inappropriately in public – dressing garishly and openly displaying male-male affection – which then draws the ire of neighbors and police alike. Outreach workers are thus often put in further danger by the very population they are seeking to empower.

All of these factors, combined with the financial burdens of intervention born by stakeholders, have contributed to “volunteer fatigue” at Alternatives-Cameroun. To date, stakeholders have implemented the association’s HIV prevention interventions on a strictly voluntary basis, usually funding their own transport and refreshment costs. Over time, however, it is becoming clear that “too much volunteer work kills volunteerism” (Stakeholder 3). At the time of writing, Alternatives-Cameroun is working to incorporate outreach-related

costs in new projects which it submits for funding. Even if Alternatives-Cameroun succeeds in providing “little motivations” for outreach workers, it is not unfathomable that, over time, the physical, emotional, and financial burdens of intervention may become too heavy for some stakeholders to bear. Clearly, the success of Alternatives-Cameroun’s “proximity approach to prevention” will be determined by the association’s ability to balance the positive and negative factors impacting on implementation.

5.2 Implications and Recommendations

This dissertation showed that some HIV prevention is taking place among MSM in sub-Saharan Africa and highlighted the factors influencing the design and implementation of these interventions in one African country: Cameroon. It did not, however, examine the efficacy of Alternatives-Cameroun’s interventions, nor did it canvas the target *nkouandengué* population about behaviors changed or difficulties encountered through participation. As such, it is impossible to know if HIV transmission is decreasing among MSM in Douala, if “hidden” MSM are being effectively reached, and if the safety of MSM participants has been ensured in the long-run. Much more research is needed, both qualitative and quantitative, to evaluate the efficacy and impact of Alternatives-Cameroun’s HIV prevention interventions. For instance, a follow-up study to Henry (2008), investigating changes in risk behaviors and HIV-related knowledge levels after interventions, would be useful. Epidemiological indicators, such as longitudinal incidence and prevalence data, are also required. Such research will pave the way for more solidly evidence-informed interventions than are currently possible in Cameroon.

From the outset, it was hoped that the results of this study would provide indications for how other NGOs in sub-Saharan Africa might begin designing and implementing their own HIV prevention interventions for MSM. The researcher suspected that Alternatives-Cameroun’s relatively long and high-profile experience might enable it to serve as a model for action elsewhere. Through the research process, however, it became clear that Alternatives-Cameroun’s interventions are truly local creations: while their basic formats and content may draw on international norms and African experiences, the translation from concept to practice required a deep understanding of local conditions, a solid connection to the target community, and the skills and motivations of a core groups of stakeholders working towards a common goal. The “proximity approach to prevention” was thus born out of larger

processes of mobilization, reflection, and exchange within the local Cameroonian context. Replicating these processes in other sub-Saharan African contexts – or even elsewhere in Cameroon – will thus likely require similarly favorable preexisting local conditions. Stakeholders, for their part, know this:

Each region, each country has its own reality. What happens in southern Cameroon is not even transposable onto northern Cameroon... As such, one must always work with the local reality. You cannot just show up with something prefabricated, perhaps from France or even from Côte d'Ivoire, and transpose it... Anything prefabricated must always be adapted to the local reality before starting to intervene. (Stakeholder 3)

But in many sub-Saharan African contexts, the “local reality” is unknown or poorly understood. Alternatives-Cameroun, for its part, benefited from Henry’s (2008) study of sexual risk behaviors among MSM in Douala, but also from having a group of core stakeholders willing and able to combine this data with their own understandings of the local *nkouandengué* community, producing interventions that respond strongly to local circumstances. For example, Alternatives-Cameroun has a medical doctor as president and an experienced outreach worker as head of its SHPU. The president also previously worked for another health-focused NGO in Douala, providing him critical insights into organizational dynamics, fundraising, and networking. In other words, Alternatives-Cameroun developed organically, strengthened by a unique mix of experience, insight, ability, and enthusiasm. Can Alternatives-Cameroun serve as a solid model for NGOs looking to launch HIV prevention interventions for MSM across Africa? The researcher suspects the answer is no. However, it does highlight two areas for further action which could lead in this direction.

First, more research is needed about homosexuality in sub-Saharan Africa. These studies must investigate not just epidemiological factors, but also the social, economic, and cultural determinants of sexual attitudes and practices. Ethnographic studies of MSM populations are equally necessary for their insights into especially “hidden” MSM: why they remain hidden, what sexual practices they engage in, and how they can be accessed through interventions. Knowing “local realities” is the first step towards designing and implementing HIV prevention interventions for MSM.

Finally, mobilization around the “MSM issue” in sub-Saharan Africa must be supported: financially, technically, and morally. This should not only target gay or MSM groupings, but also policy-makers, civil society, medical professionals, and the general

population, stressing the public health imperative for HIV prevention among MSM. Many “hidden” MSM, for instance, have multiple concomitant sexual relationships with both men and women. This could lead them to serve as “bridges” between a high-prevalence group and the general population. Sensitization and outreach programs should be careful, however, to not label MSM as “carriers of disease” – which would likely lead to further stigmatization and repression – but instead highlight their position as a vulnerable population whose particular vulnerability is heightened by homophobia. Messages should stress that criminalization, silence, and denial have no impact on the existence of homosexuality, and that all human beings – regardless of their sexual practices – have the right to protect themselves from HIV infection.

Appendix 1: Interview Questionnaire (French version)

- Situation personnelle et au sein d'Alternatives-Cameroun
 - o Depuis quand travailles-tu auprès d'Alternatives-Cameroun ? Quelle est ta fonction actuelle ? Pour quelles raisons as-tu commencé à travailler au sein de cette association ? Est-ce que tu es rémunéré pour ton travail ?
 - o Est-ce que tu es membre d'Alternatives ? Quelles sont tes motivations, de façon plus générale, de t'engager dans la lutte contre l'homophobie et contre le sida auprès des MSM ?
 - o Si cela ne te dérange pas, pourrais-je te demander ta propre identité ou orientation sexuelle ? Ton identité sexuelle a-t-elle influencé tes motivations de t'engager auprès d'Alternatives-Cameroun ? Si oui, de quelle manière ? Tu n'es pas obligé à répondre à ces questions, si tu ne le souhaites pas.

- Le contexte camerounais
 - o Quelles sortes de stigmatisation et de discrimination subissent les homosexuels au Cameroun ? Comment vives-tu ta sexualité au quotidien au Cameroun ?
 - o Selon toi, quelle est l'origine de cette stigmatisation et discrimination ? Quels sont les facteurs qui renforcent l'homophobie dans le pays ?
 - o Tu te sens plutôt optimiste ou pessimiste par rapport à l'avenir des homosexuels au Cameroun ? Pourquoi ?
 - o De façon générale, quels changements sont nécessaires pour que les homosexuels et les minorités sexuelles en général puissent vivre plus librement au Cameroun ?

- Raison d'être d'Alternatives-Cameroun
 - o Avec tes propres mots, comment définirais-tu la mission d'Alternatives-Cameroun ?
 - o Quelles sont les valeurs qu'Alternatives-Cameroun cherche à promouvoir dans la société camerounaise ? Pour toi, quelles sont les valeurs les plus importantes à promouvoir ?
 - o Comment décrirais-tu la présence et la visibilité actuelle d'Alternatives-Cameroun dans la société camerounaise ? Cette situation, est-elle stratégique ou imposée ? De quelle façon est la visibilité sociale de l'association importante par rapport à sa mission ?
 - o Quels retours as-tu reçus, de la part des bénéficiaires de l'association ainsi que de la part du grand public, concernant le travail d'Alternatives-Cameroun ?

- Les facteurs qui influencent les stratégies d'intervention choisies pour faire la prévention du VIH/sida auprès des MSM
 - o Avec tes propres mots, décris l'approche d'Alternatives-Cameroun pour faire la prévention du VIH/sida auprès des MSM.
 - o A ton avis, une approche de prévention du VIH/sida adaptée à la population MSM est-elle nécessaire ? Est-ce que cette population pourrait être ciblée efficacement dans les interventions de prévention ciblant la population générale, ou ciblant tous les hommes camerounais ?

- Si les MSM ont besoin d'une approche unique et adaptée de prévention du VIH/sida, quels sont les sujets qu'il faut impérativement aborder dans le cadre des interventions ? (*let them respond, then mention others, if they don't come up* : utilisation du préservatif et du gel lubrifiant, évaluation de son risque personnel (VCT), réduction du nombre de partenaires sexuels, début retardé des rapports sexuels, traitement des IST, etc.)
 - Comment juges-tu le niveau des connaissances dans la population MSM par rapport au VIH/sida – transmission, prévention, traitement, etc. ? Comment jugez les MSM leur propre risque à attraper le virus ?
 - A ton avis, quelle importance a l'affirmation de son identité sexuelle – en tant que homosexuel, gay, nkounandengué, ou quoi que ce soit – pour la prévention du VIH/sida ? Le « coming-out » est-il nécessaire pour lutter contre le sida auprès de la population MSM ?
 - Dans ton travail de prévention, qu'est-ce qui est le plus encourageant et le plus décourageant ?
 - Le fait de ne pas faire partie d'un réseau national de lutte contre le sida a-t-il un effet sur ton travail de prévention ? De quelle manière est un manque de partenaires locaux et nationaux problématique pour ton travail de prévention ?
 - A ton avis, quels sont les liens entre les droits de l'homme et la prévention du VIH/sida, au Cameroun ainsi que dans le monde entier ? Quels effets a l'état du droit au Cameroun sur tes actions et l'efficacité de la prévention du VIH/sida auprès des MSM ?
 - L'abrogation de l'Article 347 bis, c'est-à-dire la loi pénalisant les rapports sexuels entre les personnes du même sexe, est-elle indispensable pour lutter contre le sida au Cameroun ?
 - A côté de l'Article 347 bis, qui pénalise les rapports sexuels entre les personnes du même sexe, quoi d'autre empêche que la question des MSM apparaisse sur le plan nationale ou auprès des autres associations camerounaises de lutte contre le sida ?
- Dynamiques organisationnelles et la durabilité de l'association
- Quels aspects de la structure organisationnelle d'Alternatives trouves-tu les plus forts et les plus faibles ? Est-ce que cette structure renforce ou empêche ton travail ? De quelle manière ?
 - A ton avis, quelle importance a le « leadership » dans l'évolution et l'efficacité des associations du Sud ? Pour ton poste ? Quelles sont les qualités d'un bon « leader » associatif ?
 - Est-ce que ton engagement actuel chez Alternatives-Cameroun colle bien avec tes intérêts, connaissances, et souhaits pour ton propre avenir (personnel, professionnel...) ? De quelle manière est-ce que tu aimerais t'engager plus profondément au sein de l'association ?
 - Dans tes expériences, comment le partenariat international aide ou empêche l'évolution et le bon fonctionnement d'Alternatives-Cameroun ? Trouves-tu le partenariat international plutôt positive ou négative pour Alternatives-Cameroun ?
 - Comment juges-tu la durabilité à long terme d'Alternatives-Cameroun ? Quels sont les points critiques pour garantir la durabilité et l'évolution positive et continue d'Alternatives-Cameroun ?

Appendix 2: Interview Questionnaire (English translation)

- Professional and personal experiences at Alternatives-Cameroun
 - o How long have you been working at Alternatives-Cameroun? What is your current position or function? Why did you initially begin working with this organization? Are you paid for your work?
 - o Are you an official member of Alternatives-Cameroun? What has motivated you to get involved in the fight against homophobia and HIV/AIDS among MSM?
 - o If you don't mind me asking, how do you self-identify in terms of your own sexuality? Has your own sexual identity influenced your motivations for intervening among MSM? In what ways? You do not have to answer these questions if you feel uncomfortable.

- Cameroonian context
 - o What types of stigmatization and discrimination do homosexuals face in Cameroon? What is it like, on a daily basis, to live as a homosexual in Cameroon?
 - o To your mind, where does this stigmatization and discrimination come from? What factors reinforce homophobia in this country?
 - o Do you feel optimistic or pessimistic about the future for LGBT individuals in Cameroon? Why?
 - o In your opinion, what needs to happen or change in Cameroon in order for homosexuals to be able to live more freely in Cameroon?

- Raison d'être of Alternatives-Cameroun
 - o In your own words, what is the major objective of Alternatives-Cameroun?
 - o What values does Alternatives-Cameroun seek to promote within Cameroonian society? To your mind, what are the most important values to promote?
 - o How would you describe the presence and visibility of Alternatives-Cameroun within Cameroonian society? Is this situation a strategic choice or contextual obligation? Do you think that social visibility is important for Alternatives-Cameroun's work?
 - o What types of feedback have you received, both from MSM beneficiaries and the general public, about Alternatives-Cameroun's work?

- Factors influencing intervention strategies
 - o In your own words, describe Alternatives-Cameroun's approach for conducting HIV prevention among MSM.
 - o In your opinion, is a specific, adapted HIV prevention approach necessary for reaching MSM? Could this population be effectively reached in general-population interventions, or perhaps those which target all Cameroonian men?
 - o If MSM require a specific, adapted approach, what subjects must be addressed during interventions? (*wait for their answers, then query: condom/lubricant-use, VCT, partner reduction, delayed sexual debut, STI treatment, etc.*)

- How knowledgeable do MSM in Cameroon tend to be about HIV prevention, transmission, and treatment? What about concerning their own risk of infection?
 - To your mind, how important is sexual identity affirmation (as gay, homosexual, *nkouandengué*...) for HIV prevention among MSM? Do men need to be encouraged to “come out” as part of HIV prevention among this population?
 - In your prevention work experience, what have been the most encouraging and the most discouraging aspects?
 - Alternatives-Cameroun is not a member of the national HIV/AIDS network. Does this have an impact on your prevention work? In what ways does this local/national isolation impact on your work?
 - To your mind, what are the connections between human rights and HIV prevention? In what ways does the current human rights situation in Cameroon impact on your prevention work among MSM?
 - Is the abrogation of Article 347*bis* – the law penalizing homosexual conduct – indispensable for the fight against HIV/AIDS in Cameroon?
 - Besides Article 347*bis*, what other factors have prevented MSM from figuring in national HIV/AIDS programming and on the agendas of other civil society actors in Cameroon?
- Organizational dynamics and sustainability
- What aspects of your association’s organizational structure do you feel are the strongest? Which are the weakest? Is there anything about the way Alternatives-Cameroun is run or organized that you feel hinders your work?
 - How important is good leadership for the evolution and effectiveness of associations in the global South? What about for your job? What are good qualities for a leader to have?
 - Do you feel your current engagement with Alternatives-Cameroun is in line with your interests, skills, and wishes for your future (both personal and professional)? In what ways would you like to become more involved in the association?
 - In your experience, how do international partnerships help or hinder the evolution and functioning of Alternatives-Cameroun? Do you feel the association’s current international partners have had positive or negative impacts on the association?
 - Do you feel that Alternatives-Cameroun’s activities are sustainable in the long-term? What are the critical factors to be addressed in order to guarantee sustainability and positive growth at Alternatives-Cameroun?

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