CEDEP NEEDS ASSESSMENT

FOR EFFECTIVE IMPLEMENTATION OF HUMAN RIGHTS, HIV AND OTHER HEALTH RELATED INTERVENTIONS AMONG MSM AND WSW

IN MALAWI

Promoting Development Through Participation

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LIST OF ABBREVIATIONS AND ACRONYMS

BLM	:	Banja La Mtsogolo
FGDs	:	Focus Group Discussions
LGBTI	:	Lesbian Gay Bisexual Transgender and Intersex
MHPS	:	Malawi HIV Prevention Strategy
MSM	:	Men who have Sex with Men
NHP	:	National HIV Policy
PSI	:	Populations Services International
STI	:	Sexually Transmitted Infections
VCT	:	Voluntary Counselling and Testing
WSW	:	Women who have Sex with Women

INTRODUCTION & LITERATURE REVIEW

Malawi has a broadly conservative society that is precipitated by cultural barriers and religious ideologies that deem same sex relationships as immoral. The legal framework criminalises same-sex relationship and the penal code suggests that same-sex relationships are an unnatural offence. It is punishable by imprisonment of up to 14 years. The overt discrimination and hostile environments seriously impede efforts to protect the sexual health and rights of men who have sex with men (MSM) and women who have sex with women (WSW) hindering access to HIV prevention, treatment, care, and support services that they need (MSM GF & COC, 2012).

The Malawi environment is hostile towards MSM to the extent that the group continues to be a high-risk group in relation to HIV prevalence. Data from a Johns Hopkins, College of Medicine and CEDEP study, which used a snowball sampling method, identified 200 MSM in urban centres of Malawi. This group had an HIV prevalence of 21.4% (National AIDS Commission, 2010). Currently MSM incidence percentage by risk categoryis 4.3% against a total adult subgroup category of Risk category based on modes of transmission of 1.6 million (National Aids Commission, 2009). It is important to note that there is a conflict in data provided by MHPS on MSM prevalence data and that provided by other sources like CEDEP.

There is an obvious lack of data in relation to the HIV situation ofWSW and other LGBT in Malawi. The Malawi HIV Prevention Strategy(MHPS) only provides data for MSM and MSM femalepartners' prevalence but does not provide data for WSW, transgender people's prevalence. The situation is not unique to Malawi. Data regarding the prevalence ofWSW in the sub-Saharan Africa region are among the sparsest globally, but there is evidence that male to male sexual contact is a reality on this continent as on all others (Baral et al., 2009). Ntata et al suggests that lack of public health data on MSM is because research assume that there is isn't any public health problem faced by; MSM and WSW or they do not know how to work with MSM and WSW in these settings where the practice is illegal (Ntata, Muula & Siziya, 2008).

The Malawi HIV Prevention Strategy identifies MSM as one of the sources of new infections and provides strategies specifically targeted for MSM which include reduction of sexual transmission of HIV by reducing multiple and

concurrent sexual partners among adults through prevention messages and interventions to MSM and their female partners; and increased access to quality of and linkages between services and interventions by improving access to HIV prevention services and products to vulnerable populations through tailored interventions for populations who are vulnerable to HIV infection because of their behaviours or environments (sex workers, MSM, prisoners, etc.). Even though the strategies are there currently there is no programme that is supported by government on HIV prevention among the MSM. There is no mention of WSW or Transgender in the strategy. It is also worth noting that Malawi does not have any HIV/AIDS legislation. However the Malawi Law Commission produced an HIV/AIDS Report thattotally omits MSM andWSW (Law Commission, 2008)

Studies from Zimbabwe have shown that strategic targeting of MSM and WSW can reduce sexual transmitted infections (STI) among them. STI infections among MSM within GALZ a buddy group in Zimbabwe reduced to zero within six months compared to the previous year. When they had six requests for treatment within a six month period. The reduction was due to intervention that provided barrier methods information, water based lubricants and treatment for MSM in the group (Schorer, n.d.).

In some districts though CEDEP is implementing sexual health programmes targeting the MSM community, which aims to equip them with knowledge surrounding HIV/STI and safer sex practices. The sexual health program has so far targeted MSM individuals from Blantyre, Zomba, Mangochi, Mzuzu, Nkhata-Bay, Nkhotakota and Lilongwe and involves: national dialogue on men's sexual health, peer education, prevention using the barrier method (distribution of condoms and lubricants), the establishment of a resource centre (drop in centre), life-safe space where MSM watch HIV/AIDS documentaries and have topical discussions and a men's netball team. CEDEP has a VCT Clinic that offers friendly services to MSM community in Blantyre (MSM GF & COC, 2012). The interventions are done in a way that the MSM individuals are not exposed to the general society as homosexuality remains illegal and any programs serving the homosexuality community is regarded as criminal as it is seen as promoting illegal activities. There is hesitancy and concern amongst many HIV service implementers that if they serve this population, they may be acting illegally, since the Penal Code criminalises same-sex activity, widely understood to mean sodomy, which is anal sex (Sec 153-156 & 137A of the Penal Code (Amendment) Act No.1 of 2011 as read

withPenal Code Cap.7:01 of the Laws of Malawi).

The gay and lesbian community lack information and resources on risky sexual behaviours. Information on availability and accessibility of barrier methods like condoms, lubricants, dental dams, and female condoms is not readily available (MSM GF & COC, 2012). A recent report by CEDEP shows that a large number of MSM and WSW engage in unsafe sex and use petroleum Jelly which is risky to use with condoms (Baral et al., 2009). A report on sexual health needs in Durban, South Africa produced for lesbians and WSW revealed lack of information on the risks that WSW, lesbian and bisexual women face in engaging in unsafe sexual behaviour and lack of knowledge on how to use safer sex barrier method, these include dental dams, gloves, the use of sex toys safely and how to use male and female condoms (Durban Centre, n.d.). Such situations make LGBTI more vulnerable and exposed to STIs and HIV.

The Durban Centre study also revealed lack of knowledge and negative attitude among health service providers in serving WSW. Inability of service providers to communicate effectively and judgmental attitudes kept WSW away from receiving health treatment when in need of it. This resulted in training of health service providers and their human resources in communication and ways in which they service. Providers could advise WSW on barrier methods, safe sex and provide them with safe sex packs.

In Malawi, Namibia and Botswana,many MSM and WSW have failed to seek health care services because they were afraid of disclosing their sexual orientation status which they were afraid would cause them to be denied health care, even though prevalence of denied services to them was very low (Baral et al., 2009). A 2008 study by CEDEP found that approximately 34 percent of gay men in the country had been blackmailed or denied services such as housing or healthcare due to their sexual orientation. Additionally, 8 percent of those surveyed said police or other security forces had beaten them due to their sexual orientation.

The government has not initiated any tangible work to address identified health related problems of LGBT. There has been 'guarded' interest in interventions aimed to prevent HIV spread among men having sex with other men (MSM) in the country (Ntata et al, 2008). A recent (2011-2016) proposal to the global fund for HIV/AIDS funding by the Malawi government included

MSM and WSWs as a target group in their HIV/AIDS prevention Program (Global Fund, 2010). The proposal was unsuccessful.

Growing evidence from research on mental health of MSM and WSW populations suggests that compared with their heterosexual counterparts, gay men and lesbians suffer from more mental health problems including substance use disorders, affective disorders, and suicide (Cochran, 2001; Gilman et al., 2001). The explanation given for the cause of the higher prevalence of disorders among LGBTI people is that stigma, prejudice, and discrimination create a stressful social environment that can lead to mental health problems in people who belong to stigmatised minority groups (Friedman, 1999; Meyer, 2003). This is referred to as minority stress (Meyer, 1995). In a cross-cultural study of gay men, Ross (1985) found that anticipated social rejection was more predictive of psychological distress outcomes than actual negative experiences. Concealing one's sexual orientationis often used as a coping strategy, aimed at avoiding negative consequences of stigma, but it is a coping strategy that can backfire and become stressful (Miller & Major, 2000). Smart and Wegner (2000) described the cost of hiding one's orientationin terms of the resultant cognitive burden involved in the constant preoccupation with hiding. They described complex cognitive processes, both conscious and unconscious, that are necessary to maintain secrecy regarding one's stigma, and called the inner experience of the person who is hiding a concealable stigma a "private hell" (p. 229). Concealment of one's homosexuality is an important source of stress for gay men and lesbians (DiPlacido, 1998). Hetrick and Martin (1987) described learning to hide as the most common coping strategy of gay and lesbian adolescents, and noted that individuals in such a position must constantly monitor their behaviour in all circumstances: how one dresses, speaks, walks, and talks become constant sources of possible discovery. One must limit one's friends, one's interests, and one's expression, for fear that one might be found guilty by association.

In most of the research on LGBTI in Southern Africa, mental health issues have virtually been neglected with HIV and STI being the dominant issue.

With all this as a background, CEDEP engaged us as consultants. Using their network of contacts, CEDEP organised the interviews and focus groups with MSM, WSWs and health care providers, worked out the logistics of travel and accommodation for us to go nationwide and meet the interviewees with the following objectives:

OBJECTIVES

The purpose of this assessment is to set out:

- Evidence of the experiences of MSM and WSW people to date in health and social care.
- What is known about the target group health issues?
- Effects on social care needs of the targeted group.
- Human rights violations on this group and
- Recommend good practices in commissioning and providing assessments and services.

The aim was therefore to establish a comprehensive needs assessment report that will guide CEDEP in its interventions for MSM and WSW.

METHODOLOGY

Methods used

The consultants used a human rights based approach and were guided by qualitative research methodology. A qualitative research method was best used as this methodology draws on the narratives of people's lived experience. The two qualitative methods applied were interviews and focus group discussions (FGDs). These methods would assist us achieve the purpose of the assessment which draws on the experiences of MSM and WSW in health care.

Focus Group Discussions

We conducted 7 focus group discussions (FGDs) with MSM (6) and WSW (1) and 4 with health care providers throughout the six districts CEDEP is involved in. These ranged from 45 minutes to one and a half hours. The FGDs with health care providers were conducted in Mzuzu, Lilongwe and Blantyre. In total, 27 health care providers participated in the FGDs. Of these 9 were permanent health providers at a local prison; 3 were health care providers who work at the John Hopkins MSM/WSW friendly STIs clinic (2 research nurses and one clinical officer), 4 were health care providers at Bwaila District hospital in Lilongwe (1 ART clinic medical assistant, 1 STI clinic medical assistant, and 2 clinical officers), and 11 health providers in Mzuzu. The participants in Mzuzu came from both private and public heath care provision

facilities.All FGDs were recorded with permission from the participants.

Interviews

Individual interviews were conducted with 67 MSM and WSW using a semi structured interview schedule. Of these 58 were MSM and 9 were WSW. Participants were recruited through convenience sampling,as they were MSM andWSW known to CEDEP. CEDEP organized the participants.

Data Analysis

Interviews were analyzed using excel for the demographic data as well as the yes and no responses in the semi structured questionnaire. For the rest, the most common responses were added up. Outstanding comments are included in the results section.

FGDs were analyzed through listening to the recorded sessions and thematic analysis was done within the context of a discourse analysis framework.

RESULTS

Demographics

Nine participants (13%) identified themselves as lesbians; 39 (58%) as bisexual men; 19 (28%) as exclusively gay. Fourteen of the MSM (24% of MSM) were married while; 44 (76%) MSM were single. All of the WSW interviewed identified themselves as lesbians and single. Of all the participants, 15 (22%) had attained tertiary education against a national average of 1.4% (National Statistical Office (NSO) and ICF Macro. 2011); 48 (72%) had acquired secondary education (compared with the national average of 4.5% (National Statistical Office (NSO) and ICF Macro. 2011); only 4 of the participants (6%) had not attended secondary school compared with 70.7% nationwide (National Statistical Office (NSO) and ICF Macro. 2011). The participants' level of education therefore far exceeded the national education levels. Thirty-six (54%) were currently employed compared to national average of 69% while 31(46%) were unemployed compared to 12% national average indicating the levels of unemployment among participants is higher than the national average (National Statistical Office (NSO) and ICF Macro. 2011).The participants lived in the six districts visited. The mean age of all participants was 25.7 years.

Health care provision

Nineteen participants (28%) admitted to have ever felt afraid of seeking health care services because of their sexual orientation. All of them feared being harassed by the health care provider or arrested by the police. It was found that 12 participants (18%) have ever heard the health care providers gossiping about them because of their sexual orientation. One participant has ever been accompanied by a sexual partner to seek health care while 20 participants (30%) have accompanied a sexual partner or a fellow MSM/WSW to a health care facility. Forty-six participants (68.6%) said they would feel more comfortable being accompanied by a sexual partner or a fellow MSM/WSW to health care facility rather than going alone. Most participants reported that a fellow MSM accompanying them would make them feel more protected and less fearful of being harassed by the health care providers. One participant said he would love being accompanied had MSM/WSW activities been legal.

Nine participants(13%) reported having been denied or given a low quality health care because of their sexual orientation (1 participant was denied treatment but it was later given to him when he was accompanied by a peer educator of CEDEP). Eight felt they received low quality treatment because of the negative attitude that the health care providers showed them after their orientation was revealed. None of those who were denied or received low quality health care took action to complain against the health care providers since there reportedly is no mechanism through which to complain. Nine participants (13%) withheld information from a health care provider because of fear of revealing their orientation. Eight participants (11%) have sought sexually transmitted infection (STI) treatment; of these only 2 complained of having met health care providers that mistreated them because of their orientation. One of them said despite being given right treatment the provider became very disinterested after realising that he was MSM while the other one was mistreated verbally and behaviorally. After being treated he was asked to come a week later for review. He came for review and this time when he was exiting the treatment room he found more than a dozen health providers waiting to see him just to satisfy their curiosity and laugh at him. Another case of mistreatment by the health care providers was reported by one participant in Mangochi (the abused was not present during the focus group discussion). This patient had anal warts and when the clinician examined him he asked "What are these doing there?" The clinician had been

expecting a female patient on which to do a minor operation to remove the warts. On realising that the patient was MSM he invited fellow clinicians who came to take a look and laugh at the patient and in the end the patient was sent back without any treatment. The patient had to see a different clinician in Blantyre to get help. The patient did not go to legal bodies to set a complaint against the clinician.

Although there were not many reported cases of discrimination and stigmatisation the participants showed that they think there would be many such cases had it been that their sexual orientation was revealed each time they went to see a health care provider. All participants felt that their rights to health care, and therefore to life, are not protected by the laws of the country. The participants felt that they would be able to access good quality health care had the laws of country not been discriminating against them. Had the laws not been discriminatory, participants felt they would be open to health care providers and HIV preventive products like lubricants would be provided by the government in all the government hospitals. One participant in Mangochi had this to say:

- *"ndikalephera kunena kwa dokotala kuti ndimagonana ndiamuna anzanga ndimakumbukira kuti ndilibe ufulu wonena zakukhosi; dokotala sangadziwe bwino vuto langa"(whenever I fail to reveal my sexual orientation to a doctor I remember that I have no freedom of expression; and the doctor will not have the important information needed to diagnose my condition)-MSM, Mangochi. Other participants had the following to say:*

- *"I don't think there is any law that protects MSM/WSW and this prevents delivery of the right HIV preventive information to MSM/WSW."*- MSM, Mangochi.

- *"Zero HIV new infection cannot be achieved if the government keeps ignoring MSM/WSW."*- MSM, Mzuzu.

- *"If you are gay you cannot seek legal aid to sue anyone who has broken your human rights because the government does not believe you exist"*- MSM, Lilongwe.

- *"It is difficult to really say we are discriminated against in the health care settings because we try our best to hide our orientation."*-MSM, Mzuzu.

- *"I feel that WSW are definitely not protected by the law"*- WSW, Lilongwe.

- *"I have heard stories of fellow lesbians who were raped by men who said they raped them to force them to find men in their lives"*- WSW, Lilongwe.

There were also complaints of discrimination in settings other than health care facilities. In Lilongwe 2 girls were arrested and were in Maula prison for one full year for being suspected of being lesbians. After being released they lodged a complaint and they were compensated with MK15, 000 each. They dropped the case because no one seemed to be interested in it. While in prison they were abused in various ways e.g. being severely beaten by prison warders. Another girl, a 21 year-old, in Lilongwe was beaten up by some boys in her area because they had heard a rumour about her orientation. Almost all of the participants have reported instances of verbal abuse from peers and people who know them. It was established by this assessment that there are no legal facilities established to protect the sex minorities of this country. Majority of the participants in all the participating districts said they need establishment of community legal services where WSW/MSM can go to seek help whenever need arises. Some of the participants had this to say:

- *"The law must protect the lesbians the same way it does the rest of the Malawians"*- WSW, Lilongwe."

- *"When you present to police a case of sexual or any abuse and when the policemen realises that you are a lesbian they, instead of helping you, start laughing at you and they dismiss your case."*- WSW, Lilongwe.

- *"The laws of the country must change and protect MSM/WSW"*- MSM, Nkhotakota.

- *"The problem is government lawyers need little tips for them to help you when you need them"* MSM, Blantyre.

- *"I do not think any lawyer would feel comfortable to handle our cases unless same sex sexual relationships were legalised."*- MSM, Blantyre.

Most of the participants suggested that CEDEP should have lawyers who can be seeing to it that all cases involving MSM/WSW throughout the country are handled properly.

There was a general awareness about HIV. Fifty-six participants of the 67 (83.6%) had ever gone for HIV testing. All of those who had tested went for testing more than once. Testing occurred in both government and private facilities. The test done in all of them was voluntary, i.e., voluntary counseling and testing (VCT). The reasons for going for the test varied. The most reported reason was a desire to know one's HIV status. One participant, MSM in Blantyre, went for HIV test because he had more than 10 sexual partners and he had never used condoms because he previously had thought HIV could not be contracted through anal intercourse. Another participant, WSW in Lilongwe, went for HIV test because she feared having contracted HIV when she discovered that her girlfriend was pregnant. All MSM participants reported having multiple sexual partners. Only a few participants had knowledge of high risk sexual behavior leading to HIV among MSM.

Of the 14 participants in Mangochi, only one person knew the HIV prevalence rate was 21.4% among MSM. None of the participants in Nkhotakota and Nkhata Bay knew that HIV prevalence was higher in MSM than the general population. In Mzuzu, Lilongwe, and Blantyre the picture was slightly different; there were always 2 or 3 people who knew that HIV prevalence is higher in MSM than the general population.

Some participants admitted to have thought that HIV cannot be transmitted through same sex sexual activity. One participant in Mzuzu said: "I previously thought HIV cannot be contracted from same sex sexual intercourse. I have known that it can be transmitted through MSM sex this year." This participant had been having regular unprotected sex for 14 years. Of the few participants who thought HIV prevalence is higher in MSM thought this could be due to lack of HIV awareness information targeted towards MSM/WSW, multiple sexual partners, lack of lubricants and condoms. One participant, a 21 year-old in Mangochi said: *"it is difficult to find a man to have sex with therefore when I meet any MSM I just say 'it's my lucky day'; I would not want to scare him away by forcing him to use condom."*

It was also reported by several participants in all the 6 districts that beer was used by many of them to get rid of their fears and approach men to sleep with. Since most of the times one goes for drinking he is never prepared to meet a MSM one hardly takes condoms or lubricants with him; and the fact that one will have sex when one is very drunk makes achievement of safe sexual intercourse very difficult. Majority of the participants said it was necessary for

them to have multiple sexual partners as a way of blinding the society from discovering their true orientation. *"If you are seen with the same person everyday it will be easy for people to discover that you are MSM; therefore it is necessary that you are never seen with the same partner constantly."*- MSM, Blantyre. Apart from having multiple same sex sexual partners some MSM had multiple female sexual partners for the same reason, i.e. to cover up their orientation. One participant in Mangochi said: *"kukhala ndi akazi ndipophera awemba"(we tend to have many girlfriends because they help us blind the people)*. All the participants, in the 6 districts, complained of irregular supply of condoms and lubricants by CEDEP. While condoms can be accessed from other health facilities, lubricants are supplied by CEDEP only. In Mangochi, Nkhotakota, Nkhata Bay and Mzuzu condoms and lubricants were supplied at least 3 months ago.

The knowledge of HIV/STI was different amongst WSW. All of them thought that HIV could not be transmitted easily through lesbian sex unless one of them was unfaithful and had slept with a man. Most WSW had gone for HIV test; the most common reason for going for the test was suspicion that one's girlfriend is in a relationship with a man. It was noted that WSW were more faithful in their relationships. None of them admitted of having multiple sexual partners at any particular time. Of the few who suggested that HIV prevalence was higher in WSW than general population, they attributed their suggestion to the fact that some of the WSW are sex workers who sleep with men from whom they can contract HIV. None of the WSW reported using any protection during sexual intercourse. Apart from trusting their sexual partners, they said they engage in unprotected sex because they do not know of any place where they can get preventive materials like dental dams and finger coats.

The participants, MSM and WSW, were generally aware of STIs clinics available in government hospitals, although a few people said they did not know existence of such clinics. Most of the participants do not know of any clinics that are MSM/WSW friendly. Only in Blantyre did participants express a willingness to go to the John Hopkins clinic if they had a STI because of the MSM/WSW friendly clinic. However an interview with the health care providers at the John Hopkins STIs clinic revealed that the turn up the clinic has not improved over the past 2 years. They reported that they only see 1 or no patient in a month and that the clients almost never bring their sexual partners along.

With regard to general health related information, participants get their information primarily from the media, i.e. radio, newspapers and TV, Internet, Banja La Mtsogolo (BLM) a reproductive health NGO, CEDEP, school and government health facilities. Thirty participants (44%) get information about health related issues concerning their sexual orientation or practice from CEDEP. The rest of the participants have nowhere, apart from discussing with fellow MSM/WSW who are also not very literate in these issues. Fourteen participants (21%) said they knew where to access general counseling services. No WSW knew any place where counseling services for their sexual orientation and practices were provided. All the participants would want to receive health information specifically related to their sexual orientation and practices. This information included knowledge about STIs contraction and prevention, safe sexual practices, how to deal with relationships. All the participants also desired to have the following services made available: lubricants, condoms, and gum dams, information on sexuality issues in MSM/WSW. All of the participants would also like to see that STIs clinics are MSM/WSW friendly; for example, allow MSM/WSW to bring their sexual partners for testing, treatment and counseling. All the participants would want to see a counselor who was well trained in treatment of STIs. Most of them also wanted their counselor to be very open to people of their orientation, and have good knowledge of sexuality issues of MSM/WSW. All of the participants said they would utilise services targeted to MSM/WSW if they were available. Respect of patient/client and confidentiality were other qualities that majority would want their counselor to have. Two participants wanted their counselor to have the same sexual orientation as them. The participants expressed a wish for the MSM/WSW friendly health services to be available within their reach. They would like them to be available in government hospitals, BLM, in a private place or a separate office within the hospital where they can go without fear of feeling shy.

Twenty-five of the participants (37%) said they would not be prevented by anything to access the counseling services for their sexual orientation and practice had they been available. Four participants (6%) said they would fail to access the services because of fear of having health care providers gossiping about them. One participant would only access the services if MSM/WSW sexual activities were legal. Two participants would only go to access the services if they personally new the providers or the providers were of the same sexual orientation as them. Six participants (9%) would fail to access the services because of transport problems.

Healthcare providers Perspectives

All 23 of the health care providers in Mzuzu and Blantyre were aware of existence of National HIV Policy (NHP) while in Lilongwe no participant was aware of existence of this policy. All the participants in the three districts did not know that NHP contains information about HIV prevention and HIV/AIDS treatment in people who are in same sex sexual relationships. All 3 participants at the John Hopkins research facility in Blantyre had a good knowledge of HIV risk in MSM. They knew the current estimated HIV prevalence in MSM. These 3 health providers have been helping MSM for about three years; however they complained about small turn up to STIs clinic. They commented that it is difficult to control STIs in them because they form a network of sexual partners where it is possible that one person with a STI can infect everyone in the network. The health providers at the John Hopkins knew the specific health needs of MSM/WSW. These needs included condoms, VCT services, lubricants, STIs treatment and general health information related to MSM/WSW sexuality.

The health providers in Lilongwe and Mzuzu, despite having no awareness of NHP, thought MSM/WSW were entitled to the same rights to health as the general population. They said they did not think the MSM/WSW had more specific health need apart from general health care, STI prevention and treatment, VCT and information on general health and HIV/STI prevention. They thought that the fact that MSM/WSW cannot reveal their sexual orientation to their clinician hinders the provision of the best care available by the clinician. All of the participants in the participating districts, with exception of health providers at Chichiri prison, admitted that the country laws have prevented MSM/WSW from seeking health care without fear are very unethical and violate the MSM/WSW rights to health and life. A health provider in Lilongwe said:" I have heard that some health care providers call police when they discover their patient is MSM. I cannot do that; it is unethical. We, as health care providers, must help everybody regardless of their sexual orientation." The health care providers said despite the fact that MSM are mentioned as a high HIV risk group in NHP, the MSM will still not be able to come to hospital freely to seek care since they are still discriminated the country's law. One health provider in Lilongwe said, *"apart from failing to receive right treatment, MSM/WSW is very likely to suffer psychological trauma caused by oppression caused by our religious beliefs, cultural beliefs as well as the government."*

Most of the health care providers pointed out that there was clear conflict between the country's laws and the NHP; the laws criminalise homosexual activity whereas the NHP clearly says that MSM as a high risk group must be targeted in HIV prevention programs. All the participating health providers felt that the ministry of health is unable to do much to prevent the spread of HIV among MSM/WSW. *"How would you expect to find on hospital boards HIV awareness posters with information concerning sexual practices of MSM/WSW if the laws of the country refuse to accept the existence of MSM/WSW?"*- Health provider, Lilongwe.

That said, the health providers at one of the countries prisons had different opinions from the rest of the participating health care providers. They emphasized that the prison is to be regarded as a separate world from the general society and therefore the policies used to protect MSM/WSW would not be expected to be followed in prison settings. One participant said "prison is an island while the rest of the country is the mainland." These participants said that they are not only health providers but also law enforcers. The law requires that they arrest anyone who practices homosexuality while as the health care providers they are required to help everyone regardless of their sexual orientation. It was reported that at this prison there is a high prevalence of HIV in male prisoners. At this facility there is a system that makes sure that all prisoners are tested for STIs the first day they come in so that it should be easy to know whether they later contract STIs from fellow prisoners. This system has several times revealed that same sex sexual intercourse is happening in the prison. There is a significant number of prisoners who come to ART clinic in the prison. There have been several cases of rape. That said, the prisoners are not supplied with condoms and lubricants. The health care providers said it would be unlawful to supply such things to prisoners since all prisoners who are found doing sex with fellow men are charged with further 14 years for practicing homosexuality. it was admitted by the prison health care providers that they report to police all cases that present to their clinic with STI that shows that it was most probably contracted from a man. Despite accepting the ethical reasons for providing health care to all people regardless of their orientation, they said they will continue treating the MSM/WSW as criminals until the laws of the country change. They said providing condoms would be the same thing as telling the prisoners to start sleeping with fellow men without fear."You do not give a child bread without expecting him to eat it; so do you expect us to be advocating 'sodomy' by supplying the prisoners with condoms?" - One of the

health providers at prison. In brief, the health care providers at Chichiri prison were not willing to change their way of health care provision in MSM/WSW unless the laws of the country changed first.

That said, the health care providers suggested several things that must be done to improve the effectiveness of HIV prevention in MSM/WSW and, therefore, the general population. All the participating health providers said would like to see the laws of the country changed to uncriminalise homosexuality. They said this would help in treatment of STIs in MSM/WSW partners and would ensure that MSM/WSW rights to health and, therefore, to life are respected. Others suggested having MSM/WSW human rights posted on hospital walls and having a good system through MSM/WSW can lodge complaint when their rights have been broken.

DISCUSSION

The assessment has shown that there is poor implementation of the policies which seems to recognise the existence of MSM but targeted intervention towards them is clearly lacking. The WSW are not specifically recognised in any Malawi Government policies. It is therefore clear there are inconsistencies between the laws and policies of the Malawi Government in so far as these touch on issues of HIV on the one hand, and persons engaged in same sex-relations, on the other. The Penal Code criminalises same sex relations and research shows that criminalisation drives MSM and WSW underground and makes them more vulnerable to HIV infection and other STIs. The 2003 National HIV and AIDS Policy specifically acknowledges that there are persons who engage in same sex relationships and that if these are not accorded access to prevention, education, treatment, care and support, they may in fact endanger others. In addition, the Malawi Government undertakes to 'put in place mechanisms to ensure that HIV and STI prevention, treatment, care and support can be accessed by all without discrimination, including people engaged in same sex sexual relations'. The fact that same-sex relations are illegal in Malawi is used as a justification for not providing any specific health related services required by MSMs and WSWs in spite of the undertaking and commitment by the Malawi Government in its policies.

The assessment further revealed that with the exception of some health service providers, the vast majority of them were totally ignorant of MSM and WSW issues as these are never taught to them during their training or orientation. In fact, some of them heard these issues during the assessment itself. The few that had an idea about MSM and WSW issues learnt them through trainings conducted by either CEDEP, PSI Malawi or workshops on sexual and reproductive health rights outside Malawi. This state of affairs does affect how health service providers will render services to MSMs and WSWs. MSMs and WSWs cannot be wished away. They were there, they are here with us and will always be there.

With regard to the policies, many health service providers had heard about some policies, for instance, the 2003 National HIV and AIDS Policy and the Malawi Constitution but were not conversant with their contents on specific issues. The general trend is that it is persons in higher positions such as

District Health Officers, Matrons e.t.c who attend seminars and workshops on some of these and when they return, there is no effort to share the information or knowledge gained with others. The bosses usually keep a copy of these materials in their offices.

The assessment unearthed another concern that affects MSMs and WSWs. In the few instances where an MSM or WSW felt ill-treated by a health service provider, they had nowhere to go and complain within the healthcare setting. This concern would of course apply with equal force to heterosexual persons.

With the exception of Mzuzu, Lilongwe and Blantyre, all the districts in Malawi that were visited, namely, Nkhata Bay, Nkhotakota and Mangochi do not have legal aid services where indigent members of society can go and seek legal assistance if they have been abused or their human rights have been violated. Even in the districts where there is a government legal aid service, MSMs and WSWs felt they could not receive appropriate service because 'lawyers working in [Malawi] government do not appreciate our struggles and concerns and we have no confidence in them'. While it is difficult to have tailor made legal services in every district, at a minimum, where there is government legal aid services, the lawyers must be sensitised on MSMs and WSWs so that MSMs/WSWs can in return have confidence in them.

It was also clear that a greater majority of the healthcare service providers were totally unaware of the health needs and issues for MSMs and WSWs. Health care service providers are key to the other issue relates to the packaging of HIV prevention information. The classic example relates to instructions in condom packets. The illustrations given only show a man and a woman as if a condom can only be used between a man and a woman and not between a man and a man or a woman and a woman in case of a diaphragm.

There is also a dearth of literature generally on MSM and WSW issues in Malawi as if they do not exist in Malawi. This state of affairs is also responsible for the social and cultural vulnerability to prevailing homophobic attitudes towards such people. MSMs and WSWs also lacked the most basic information on the various studies conducted by CEDEP itself such as the HIV prevalence rate among MSMs in Malawi.

Healthcare service providers need to strike a proper balance between being

healthcare providers and their other roles in society such as parenthood, religious convictions, other professions they have and their own sexual orientation. They are first and foremost healthcare providers when they are in a healthcare setting and everything else should be secondary and should remain true to their Hippocratic oath or pledge and not allow their own personal prejudices to cloud their judgment as such providers and cross the acceptable lines of ethics to other considerations.

The fear of being reported by the health care provider stood out as a reason for not disclosing one's sexual orientation. However, the Medical Council of Malawi Code of Ethics and Professional Conduct is clear on what is expected of health care providers in professional settings especially with regard to the issue of reporting the client. Most participants spoke of this being their greatest fear and those who were ill treated reported that the health workers turned them into a spectacle in clear breach of: "The practitioner shall be expected to report to appropriate authorities when there are grounds for suspecting that he patient has been subjected to an illegal procedure or is the victim of criminal poisoning" .

The lack of consistent sexual health education was pronounced in this assessment. MSMs require water-based lubricants which are not provided by any government or private hospitals or clinics in the country in spite of the commitments by the Malawi Government to ensure HIV and STI prevention, care and support to all people including MSMs. Condoms are provided by government and private hospitals and MSMs do access them. However, there are times when these are completely out of stock. For MSMs to have safe sex, they require both lubricants and condoms. During one FGD in Lilongwe with healthcare providers, it was learnt that there are some women who are unable to produce vaginal fluids in readiness for sexual intercourse and that the lubricants may also be accessed by such heterosexual women.

WSWs like MSMs also require condoms. Condoms are useful when sex toys are shared between or among WSWs or when they engage in high risk sexual activities such as shaffing and tribadism. In addition to condoms, WSWs also require dental dams for oral sex and anal rimming or licking. They also require finger cots for fingering. With the exception of condoms, dental dams and finger cots are not provided by any government or private hospitals in Malawi to WSWs, yet the possibility of HIV transmission between two women is there, regardless of the fact that it is low.

The area of mental health and MSM/WSW has been neglected and this came out clearly with regard to the needs of the particiapants. There are no counselling services for general life and well being. Mental health embraces a person's quality of life. Mental health is not simply the absence of mental disease but "a state of well-being in which the individual realises his or her own abilities, can work productively and fruitfully, and is able to contribute to his or her community" (World Health Organisation, 2005). In order to enable a person to contribute meaningful to the community, MSM/WSW need support and input on issues that affect their lives directly, such as the coming out process, maintaining relationships and coping with stigma and stress.

CONCLUSION AND RECOMMENDATIONS

Our conclusion and recommendations fall into two broad categories. There is the advocacy level recommendations, which are more long term and require lobbying at the macro level. There are the more immediate intervention recommendations which CEDEP can engage in.

Advocacy level

1. Inconsistencies between laws and policies

It is recommended that the laws and policies should be consistent on issues of HIV and STIs when dealing with persons who engage in same sex relations. If Malawi is to achieve the zero rate infection of HIV, then, decriminalisation of same sex relations is the way to go so that in turn the policies can be implemented without any problems. CEDEP should lobby for the harmonisation of policies and laws by recognising MSM and WSWs as well as ensuring the practical implementation of the policies which will necessitate decriminalisation.

2. Decriminalise homosexual activities

Laws criminalising homosexual activities are driving MSMs and WSWs underground and making them unable to access HIV prevention, care and support services. This may in turn make the zero infection rate quest untenable. The laws are also used as an excuse by ignorant health service providers for not providing HIV prevention services to MSMs generally and in prisons specifically, contrary to the dictates of the 2003 National HIV and AIDS Policy and also the National HIV Prevention Strategy 2009 to 2013. CEDEP needs to continue advocacy for the repeal of this law.

3. Incorporation of MSM and WSW issues in syllabuses for training institutions for health personnel

If Malawi cares about human rights of its citizens including sexual minorities, it is recommended that health issues of MSMs and WSWs be incorporated into the syllabi for training or orientation institutions for all health personnel. CEDEP needs to facilitate this so that the benefits trickle down to the MSM/WSW in the long term.

4. Sensitisation of policies and laws

There is therefore need to sensitise all health service providers on health related policies and laws, if these are to be effectively implemented. Sensitisation of Code of Ethics of Medical Council of Malawi. Citizens (MSM/WSW) also need to be sensitised to the existing laws. CEDEP needs to lobby for this.

5. Lack of Guidelines in handling MSM/WSW

There is need for guidelines on how to handle MSMs and WSWs. There is no law that requires a healthcare service provider to report an MSM or WSW to the Police for disclosing that they are gay or lesbian. In fact, it is a total breach of confidentiality for which a healthcare service provider may be sued for violation of breach of the right to privacy. In cases, where a healthcare service provider is not sure how to handle a particular situation, he or she needs to explain to the person and seek his or her consent whether he can consult or indeed invite a colleague to assist him or her. Healthcare service providers must swallow their pride and play it safe rather than appear to be a know-all sort of provider, and in the end land into problems.

6. No clear complaints mechanism channels within healthcare settings

It was seen that there are no clear channels for the voicing of grievances should MSM/WSW so feel when receiving healthcare provision. It is recommended that, each healthcare setting must have a clear complaints mechanism channels that must be resorted to by those who feel abused, or whose rights will have been violated by healthcare service providers. CEDEP needs to lobby for this.

7. No tailor made legal aid services

It was suggested that if things will not work out, then CEDEP must help in identifying one legal person who can be accessed by all MSMs and WSWs in Malawi to assist them with their legal/human rights issues. Facilitation of lawyers of MSM/WSW issues and educate MSM/WSW about legal services available.

8. Lack of provision of lubricants and inconsistent supply of condoms, dental dams and finger coats

It is recommended that the Malawi Government should live up to its commitment by ensuring that water-based lubricants are available for free in all government hospitals and clinics and so too private hospitals and clinics and accessible to all that require them including MSMs. CEDEP needs to lobby for this. It is recommended that dental dams and finger cots should be accessible in both government and private hospitals and clinics to all persons that require them.

Intervention

9. Education on Safe sex practices

CEDEP should provide regular health information on sexual practices pertaining to the MSM/WSW orientation and create a forum where dialogue and questions can be asked by MSM and WSW.

10. Lack of Information on MSM/WSW health issues

It is recommended that HIV and STI prevention information should be MSM and WSW friendly and literature should be available so that people are aware of MSMs and WSWs and their needs and CEDEP should strive to disseminate its research findings among its members.

11. Lack of counselling services

There is need to provide counselling services to MSMs and WSWs on who they are, HIV and STI prevention and other issues. The provision of Mental Health services and workshops to adress oft negelected isues such as self esteem, relationships and the coming out process. CEDEP needs to facilitate this.

12. Facilitate social support system for WSW

CEDEP has a unique opportunity to meet a dire need among WSW of organising them into a grouping with regular meetings and health education. This is very much needed.

REFERENCES

Baral S, Trapence G, Motimedi F, Umar E, Iipinge S, et al. (2009) HIV Prevalence, Risks for HIV Infection, and Human Rights among Men Who Have Sex with Men (MSM) in Malawi, Namibia, and Botswana. PLoS ONE 4(3): e4997. doi:10.1371/journal.pone.0004997

Beyrer, C., Trapence, G. &Motimedi, F. et al. (2010).Bisexual concurrency, bisexual partnerships, and HIV among Southern African men who have sex with men (MSM).Sex Transm Infect published online April 21, 2010 doi: 10.1136/sti.2009.040162

Cochran SD. Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? American Psychologist 2001;56:931–947. [PubMed: 11785169]

DiPlacido, J. Minority stress among lesbians, gay men, and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In: Herek, GM., editor. Stigma and sexual orientation: Vol. 4. Understanding prejudice against lesbians, gay men, and bisexuals. Thousand Oaks, CA: Sage; 1998. p. 138-159.

Durban Centre. (n.d.). My body, your body, our sex: A Sexual Health Needs Assessment For Lesbians and Women Who Have Sex With Women, Durban, South Africa.

Friedman RC. Homosexuality, psychopathology, and suicidality. Archives of General Psychiatry 1999;56:887–888. [PubMed: 10530629]

Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Risks of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. American Journal of Public Health 2001;91:933–939. [PubMed: 11392937]

Global Fund. (2010). Proposal Form – Round 10.Single Country Applicant. Sections 3-5 HIV. Malawi submission.

Hetrick ES, Martin AD. Developmental issues and their resolution for gay and

lesbian adolescents. Journal of Homosexuality 1987;14(1–2):25–43. [PubMed: 3655346]

Law Commission (2008). Report of the Law Commission on the Development of HIV and AIDS Legislation. Law Commission Report No.20. Lilongwe: Government of Malawi

Meyer IH. Minority stress and mental health in gay men. Journal of Health and Social Behavior 1995;36:38–56. [PubMed: 7738327]

Meyer, I. (2008). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. Psychol Bull. 2003 September ; 129(5): 674–697.

Miller, CT.; Major, B. Coping with stigma and prejudice. In: Heatherton, TF.; Kleck, RE.; Hebl, MR.; Hull, JG., editors. The social psychology of stigma. New York: Guilford Press; 2000. p. 243-272.

MSM GF & COC (2012) Malawi: A Baseline on the health & human rights situation of LGBT & other key populations. MSM GF Bridging the Gap Health Rights for Key Populations. COC Netherlands & Global Forum on MSM & HIV in partnership with CEDEP.

National Aids Commission. (2010). Operation Plan of the National HIV Prevention Strategy: Phase One October 2009 – June 2011. Lilongwe, Malawi: Author

National Aids Commission (2009). National HIV Prevention Strategy 2009 To 2013. Lilongwe, Malawi: Author

National Statistical Office (NSO) and ICF Macro. 2011. Malawi Demographic and Health Survey 2010. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

Ntata, P., Muula, A. &Siziya, S. (2008). Socio-demographic characteristics and sexual health related attitudes and practices of men having sex with men in central and southern Malawi. Tanzania Journal of Health Research Volume 10, No. 3.

Ross MW. Actual and anticipated societal reaction to homosexuality and adjustment in two societies. Journal of Sex Research 1985;21:40–55.
Sec 153-156 & 137A of the Penal Code (Amendment) Act No.1 of 2011 as read with Penal Code Cap.7:01 of the Laws of Malawi.

Schorer (n.d.) MAN TOT MAN', a joint approach on sexual health of MSM in the Netherlands via the Internet.

Smart, L.; Wegner, DM. The hidden costs of stigma. In: Heatherton, TF.; Kleck, RE.; Hebl, MR.; Hull, JG., editors. The social psychology of stigma. New York: Guilford Press; 2000. p. 220-242.

World Health Organisation. (2005). Promoting Mental Health: concepts, emerging evidence, practice: report of the world health organisation, Dept of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation & the University of Melbourne. Geneva: World Health Organisation.

APPENDICES

APPENDIX 1: Needs Assessment Semi Structured Interviews Questionnaire
APPENDIX 2: Health Care Providers: Key Informant Interview Guide
APPENDIX 3: Focus Group Discussion Guide

APPENDIX 1
NEEDS ASSESSMENT SEMI STRUCTURED INTERVIEWS QUESTIONNAIRE

Demographic Data

Age:
Highest level of your education:
Current employment status:
Current Occupation:
Location of residence:
Sexual orientation:
Gender:
Marital status:
Nationality:

Health Care Experience

1. Have you felt afraid to seek health care services as a result of your sexual orientation or practice?
2. Describe any such experience

3 a. Have you ever been denied health services as a result of your sexual orientation or practice?
   b. What did you do about it?

4 a. Have you ever withheld information from a health care provider because of fear of their response to your sexual orientation or practice?
   b. What information
   c. Why?
   d. What did you then do about it?

5 a. Have you felt that you have received lower quality of care as result of your sexual orientation or practice?
   b. What information
   c. Why?
   d. What did you then do about it?

6. Have you ever sought STI treatment? Where did you get treated? Why did you go to that facility to seek treatment services? What influenced you to make the decision?
7. Was there any aspect of the STI related services or clinics that you were uncomfortable with?
8. Have you ever been tested for HIV?
9. Was your consent sought before being tested?
10. Do you know what sort of test it was that was carried out on you?
11. Where did you get tested? Describe what influenced you? Describe why you decided to seek the test.
12. Were you counselled before and after the test?
13. Are there places here where one can go to, to seek HIV comprehensive health care service for MSM/WSM community? Describe which services are offered in the facility? What motivates you to seek health care services in that facility? What challenges do you face in order for you to receive services?
14. Where do you currently get information about general health related issues?
15. Where do you currently get information about health related issues concerning sexual orientation or practice?
16. Where can you go to access health care? What is available for you?
17. What other health care services would you like to see made available?
18. What health information would you like to receive pertaining to sexual orientation or practice?
19. What factors prevent you from receiving general health care?
20. What factors prevent you from accessing health care because of your sexual orientation or practice?
21. What factors do you feel would enable you to access adequate health care?
22. Have you been tested for HIV without consent as a result of your sexual orientation?
23. Have you heard health care providers gossiping about you because of your sexual orientation or practice?
24. When you have gone to a health facility, have you felt any change in how much you worry about how health care providers will act towards you based on your sexual orientation?
25. What would you like to see provided for MSM/WSW health care services?
26. What information would you want to be provided to health care workers about MSM/WSW issues?

27. Have you been accompanied or accompanied a partner/ fellow MSM/WSW to access health care? What was the experience like?
28. Is this something you would want or be comfortable with? Why or why not?
29. What is currently working with regard to health care that you would like to see improved upon?
30. Are there counseling services provided for sexual orientation or practice issues?
31. What counseling service would you like to see provided?
32. Would you utilize these counseling services?
33 a. Have you ever gone for HTC?
    b. Describe your experience
    c. Have you withheld information?
    d. What information?
    e. Why?
34. What training would you want the counselor to have?
35. Where would you want the counseling services to be available?
36. What would prevent you from accessing the counseling service?
37. Any other issue or thing you want to say?

Notes

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