Mapping & appraisal of HIV prevention & care interventions for men who have sex with men (MSM) in Kenya, Tanzania, Uganda & Zimbabwe: A report of the SHARP programme

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CONTENTS

Acknowledgements ......................................................................................................................... 02

Contents ........................................................................................................................................... 03

Tables of case studies ..................................................................................................................... 05

Glossary of key terms ..................................................................................................................... 06

Summary of report contents ........................................................................................................... 08

1. Overview of appraisal findings & recommendations ................................................................. 09
   1.1 The method of appraisal ......................................................................................................... 10
   1.2 Overview of key findings ...................................................................................................... 11
       1.2.1 Community engagement and representation .............................................................. 11
       1.2.2 Security, safety and social context .............................................................................. 12
       1.2.3 Resilience and innovation .......................................................................................... 12
       1.2.4 Partnerships and multi-sectoral programming ............................................................ 12
       1.2.5 Holistic and enabling environments .......................................................................... 13
       1.2.6 Training, resource and organisational capacity .......................................................... 13
   1.3 Recommendations ................................................................................................................ 13
       1.3.1 Recommendations for individual level interventions .............................................. 13
       1.3.2 Recommendations for community & structural level interventions ...................... 14
       1.3.3 Recommendations for service level interventions ...................................................... 14

2. Background .................................................................................................................................. 15
   2.1 Epidemiology ....................................................................................................................... 16
   2.2 HIV and sexual health need ................................................................................................. 17
   2.3 Legal situation, abuse and discrimination ........................................................................... 18
   2.4 Regional interventions ......................................................................................................... 20
   2.5 Aims ........................................................................................................................................ 21

3. Methodology ................................................................................................................................ 22
   3.1 Overall approach .................................................................................................................... 23
   3.2 Methods of addressing objectives 1 & 2 ............................................................................. 23
   3.3 Methods of addressing objectives 3 & 4 ............................................................................ 27
   3.4 Analysis of data and development of recommendations .................................................... 28

4. Individual level interventions ...................................................................................................... 29
   4.1 Engaging MSM ..................................................................................................................... 30
   4.2 Overview of existing interventions ...................................................................................... 31
   4.3 Intervention appraisal .......................................................................................................... 32
4.3.1 1 to 1 information and advice ................................................................. 32
4.3.2 Group information and advice .................................................................. 38
4.3.3 1-to-1 clinical interventions ..................................................................... 41
4.3.4 Broadcast and social media ...................................................................... 44
4.3.5 Distribution of condoms and lubricant...................................................... 47

5. Community and structural level interventions ................................................. 49
5.1 Engaging the community and policy/decision makers .................................. 50
5.2 Overview of community/structural level interventions ................................. 50
  5.2.1 Enhancing the connectedness and resilience of the MSM community ........ 51
  5.2.2 Encouraging supportive communities...................................................... 54
  5.2.3 Sensitisation of religious, traditional or other community leaders............. 56
  5.2.4 Policy advocacy & lobbying..................................................................... 56

6. Service level interventions ................................................................................ 59
6.1 Engaging service provider ........................................................................... 60
6.2 Overview of service level interventions:....................................................... 60
  6.2.1 Mapping, monitoring and vetting of service providers............................... 60
  6.2.2 Sensitisation training of service providers............................................... 61
  6.2.3 Development and adaptation of training materials ................................... 62
6.3 Intervention appraisal ..................................................................................... 63

7. Organisational development ............................................................................ 65
7.1 Development of organisational systems ......................................................... 66
7.2 Development of organisational resilience...................................................... 66
7.3 Development of networks and partnerships.................................................. 67

8. Imagining the future .......................................................................................... 68
8.1 Recommendations for individual level interventions ..................................... 69
8.2 Recommendations for community & structural level interventions ............... 70
8.3 Recommendations for service level interventions ......................................... 70
8.4 Recommendations for future research ......................................................... 71
  8.4.1 Opportunities for evaluation of discrete interventions............................... 71
  8.4.2 Formative research possibilities................................................................. 72

APPENDIX A SHARP Interventions appraised ...................................................... 73
During this report, we describe 14 interventions that we believe are crucial to the success of the HIV prevention and care interventions for MSM in this region. These have been selected on the basis of the key components of intervention effectiveness, as described in Chapter 3, and represent good practice across the full range of individual, community and service level interventions currently being delivered.

### TABLE OF CASE STUDIES

<table>
<thead>
<tr>
<th>Case study number</th>
<th>Intervention type</th>
<th>Description</th>
<th>Delivery organisation</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Individual level intervention – Engaging MSM</td>
<td>MSM hotspot mapping in neighborhoods of Dar es Salaam</td>
<td>SANA &amp; CHESA, Tanzania</td>
<td>31</td>
</tr>
<tr>
<td>2</td>
<td>Individual level intervention – Engaging MSM</td>
<td>Social media use and online social networking</td>
<td>IBU, Uganda</td>
<td>34</td>
</tr>
<tr>
<td>3</td>
<td>Individual level intervention – 1 to 1 information &amp; advice</td>
<td>Using social media to engage MSM</td>
<td>GALZ, Zimbabwe</td>
<td>37</td>
</tr>
<tr>
<td>4</td>
<td>Individual level intervention – Group information &amp; advice</td>
<td>HIV Post-test club</td>
<td>ISHTAR, Kenya</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
<td>Individual level intervention – 1 to 1 clinical</td>
<td>Mobile testing and screening</td>
<td>IBU, Uganda</td>
<td>44</td>
</tr>
<tr>
<td>6</td>
<td>Individual level intervention – broadcast media</td>
<td>Facebook media work</td>
<td>GALZ, Zimbabwe</td>
<td>45</td>
</tr>
<tr>
<td>7</td>
<td>Individual level intervention – broadcast media</td>
<td>Radio broadcasts</td>
<td>MAAYGO, Kenya</td>
<td>46</td>
</tr>
<tr>
<td>8</td>
<td>Community/structural level intervention – enhancing resilience and connectivity</td>
<td>Combined internal and external community building events</td>
<td>GALZ, Zimbabwe &amp; SANA, Tanzania</td>
<td>52</td>
</tr>
<tr>
<td>9</td>
<td>Community/structural level intervention – enhancing resilience and connectivity</td>
<td>The REAct human rights monitoring and response system</td>
<td>SMUG &amp; IBU (Uganda)</td>
<td>53</td>
</tr>
<tr>
<td>10</td>
<td>Community/structural level intervention – encouraging supportive communities</td>
<td>“Stop hate” community support</td>
<td>Youth on Rock, Uganda</td>
<td>55</td>
</tr>
<tr>
<td>11</td>
<td>Community/structural level intervention – Sensitisation of religious or community leaders</td>
<td>Sensitisation of local chiefs in Western Kenya</td>
<td>MAAYGO, Kenya</td>
<td>56</td>
</tr>
<tr>
<td>12</td>
<td>Community/structural level intervention – advocacy and lobbying</td>
<td>Documentation of human rights abuses</td>
<td>SANA, Tanzania</td>
<td>58</td>
</tr>
<tr>
<td>13</td>
<td>Service level intervention – mapping, vetting and monitoring of services</td>
<td>Mystery shopper monitoring of services</td>
<td>GALZ, Zimbabwe</td>
<td>61</td>
</tr>
<tr>
<td>14</td>
<td>Service level intervention – sensitisation of health providers</td>
<td>Healthcare working sensitization training</td>
<td>MAAYGO, Kenya</td>
<td>62</td>
</tr>
<tr>
<td>TERM</td>
<td>DEFINITION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome. The condition caused by the HIV virus if left untreated.</td>
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<tr>
<td>ART or ARV</td>
<td>Anti-Retroviral Therapy or Anti-Retro Virals. This is the treatment regime or drugs used by HIV positive people to control their HIV infection.</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation. An organisation composed of or rooted in the community it aims to serve.</td>
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<tr>
<td>Evaluation</td>
<td>The critical assessment of the value of an activity</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus. The virus that untreated leads to the condition called AIDS.</td>
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<td>HIV Care Cascade or Care Continuum</td>
<td>Term used to describe the stages of HIV care through which individuals ideally pass, from diagnosis to suppression of viral load and (hopefully) good health.</td>
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<tr>
<td>Impact evaluation or Outcome evaluation</td>
<td>An evaluation that seeks to establish whether or not an intervention brought about its strategic aim.</td>
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<tr>
<td>Implementing Partner</td>
<td>Term used by the SHARP programme to describe the LGBTI/MSM CBOs.</td>
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<tr>
<td>Intervention</td>
<td>A purposeful activity intended to effect change in a defined group of people.</td>
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<tr>
<td>Incidence</td>
<td>The rate of new cases of a disease or trait, which therefore includes time in the unit of measurement. For example, incidence of 6 new cases of HIV per 100 person-years.</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex.</td>
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<td>Linking organisation</td>
<td>A local partner of the International HIV/AIDS Alliance, responsible for management of the programme in each country.</td>
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<td>MARPs</td>
<td>Most at risk populations: a term often used to describe groups at very high risk of HIV, such as MSM, people who inject drugs or people who sell sex.</td>
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<tr>
<td>Monitoring</td>
<td>The systematic collection and collation of information about the performance of an intervention or programme as it progresses. Monitoring must be based on targets set and activities agreed during the planning phases for an intervention.</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men. This term is used to include men regardless of how they define their sexual identity.</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation. For example, the International HIV/AIDS Alliance or Tanzania Health Promotion Support.</td>
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<td>Peer educator</td>
<td>A member of the target population or community who an organisation aims to reach who has received training to impart information, advice and distribute health promotion materials.</td>
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<tr>
<td>Prevalence</td>
<td>The proportion of a population with a trait or disease at any one point in time</td>
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<td><strong>Sensitisation</strong></td>
<td>A set of activities designed to bring awareness of, encourage empathy and understanding towards a group of people, in this case MSM, to another group, in this case typically service providers. It is in contrast to provision of specific technical information, though could complement it.</td>
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<td><strong>SHARP</strong></td>
<td>Men’s Sexual Health and Rights Programme. International HIV/AIDS Alliance programme supporting CBOs (or ‘implementing partners’ in the programme language) in Kenya, Uganda, Tanzania and Zimbabwe.</td>
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<td><strong>STI</strong></td>
<td>Sexually Transmitted Infection.</td>
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<td><strong>Target population</strong></td>
<td>The group of people for whom an intervention is intended.</td>
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<td><strong>VCT</strong></td>
<td>Voluntary Testing and Counselling, generally meaning for HIV.</td>
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This report summarises the rationale, methods and findings of an in-depth appraisal of targeted HIV prevention and care interventions for men who have sex with men (MSM) in Kenya, Tanzania, Uganda and Zimbabwe. The appraisal was commissioned in support of a four-country initiative called the Sexual Health and Rights Programme (SHARP), coordinated by the International HIV/AIDS Alliance, which seeks to build capacity among community based organisations to deliver targeted HIV prevention and care interventions for MSM.

This appraisal examines, in detail, how interventions commissioned as part of the SHARP programme are performing and addresses the key monitoring and evaluation questions: are we doing the right things, and are we doing them well? As part of the appraisal process, we examined the social and cultural factors that support or challenge intervention delivery and consider the relative strengths of different intervention types. While not an outcome or end-user evaluation, the findings and intervention descriptions contained within the report will help in the design of new programmes for MSM, and their evaluation, as well as supporting lobbying efforts for extra resources to meet unmet HIV prevention, treatment and care needs for this population.

Interviews and focus groups were conducted with staff and peer educators of all community based organisations participating in the SHARP programme, as well as other MSM organisations and stakeholders within the MSM HIV response. We examined a series of key interventions delivered by each organisation and assessed them according to the criteria for intervention effectiveness: feasibility; acceptability; coverage and access; need; effectiveness; and efficiency. Findings are presented according to intervention type and considered in terms of programme strengths, capacities for impact, and challenges to implementation.

This report will be of use to any individual or organisation seeking to deliver, commission or fund targeted HIV prevention, treatment or care interventions for men who have sex with men in Kenya, Tanzania, Uganda or Zimbabwe and who wishes to understand, in detail, the factors associated with intervention performance. As many of the determining social, cultural and economic factors are similar in neighbouring countries, they may also be of value to those working in other parts of Eastern and Southern Africa.

HOW TO USE THIS REPORT

An in-depth appraisal was undertaken of a large number of interventions. For a summary of the key findings from across all of the interventions see Chapter 1 (page 9). For a detailed account of specific interventions, see the corresponding Chapters 4 (Individual level interventions), 5 (Structural & community level interventions) and 6 (Service level interventions). For key recommendations relating to policy, practice and future research, see Chapter 8. A detailed description of the appraisal and intervention description language used can be found in Chapter 3.

Throughout Chapters 4 to 6 we include case studies from SHARP partner organisations that illustrate innovative approaches and/or challenging circumstances for HIV prevention and care among MSM in the four countries. These were selected on the basis of success they have demonstrated in meeting their stated aims, and are considered crucial to programme as it moves forward.
1. OVERVIEW OF APPRAISAL FINDINGS & RECOMMENDATIONS

This report describes an appraisal of HIV prevention and care interventions delivered by MSM-led community based organisations (CBOs) in Kenya, Tanzania, Uganda and Zimbabwe. These interventions are delivered as part of the Sexual Health and Rights Programme (SHARP), an initiative coordinated by the International HIV/AIDS Alliance and funded by the Danish Department for International Development (DANIDA). As of December of 2015, the SHARP programme had reached a total of 14,900 MSM across the four partner countries.

This chapter provides a brief overview of key findings and presents a series of themes that capture issues identified within and across each intervention type. Here we describe only ‘top level’ findings, and readers are encouraged to refer to the appropriate chapters that follow for a detail account of each intervention.
1. OVERVIEW OF APPRAISAL FINDINGS & RECOMMENDATIONS

This appraisal involved the careful assessment of 39 interventions delivered across the seven CBOs who make up the SHARP partnership. Interviews and focus groups with CBO staff and peer educators, as well as meetings with key stakeholders in each country, considered the aims and objectives of each intervention before assessing their performance in relation to seven key indicators of intervention effectiveness (described in detail in Chapter 2).

Within the remainder of this report, the following typology of interventions is used:

**Individual level interventions:** Those which communicate, or intervene, directly with MSM who are the target of the SHARP programme (Chapter 4).

**Community & structural level interventions:** Those which seek to improve the social or cultural environment within which MSM live to improve their quality of life and facilitate targeted HIV prevention and treatment activities (Chapter 5).

**Service level interventions:** Those which seek to increase the capacity or accessibility of services that MSM need to access, such as MSM sensitisation training in healthcare settings (Chapter 6).

In the following sub-sections, we describe SHARP interventions within the typology outlined above, articulating their aims and objectives. These aims were established in discussion with the CBOs and the tables in each sub-section reflect the range of aims and objectives that interventions might seek to meet. No intervention could hope to meet all of these aims, and not all CBOs will specifically attend to all intervention types, or have all of these aims.

For each intervention type, we begin by articulating the aims and objectives as described by the participating organisation. Following this we examine the ability and capacity of organisations to meet these aims and objectives. The appraisal examined each intervention in light of its feasibility, acceptability, coverage and equity of access, cost, need, effectiveness and efficiency. Given significant overlaps, we collapse these into three key sections for reporting.

1.1 THE METHOD OF APPRAISAL

(1) **Strengths:** objective assessments of the intervention that consider the overarching principle and values that might determine effect.

(2) **Capacity for impact:** while not an impact evaluation, this appraisal enables us to highlight dimensions of the interventions that are essential for impact to be realised (e.g. while on the basis of this appraisal we cannot say that an intervention does work, we can say that it has the capacity to do so, given its components).

(3) **Challenges to implementation:** issues that impact on the ability of CBOs to meet the aims of their interventions, or reflections on interventions where effectiveness is unclear.

This appraisal does not constitute a programme impact assessment. The ultimate goal was not to assess whether the programme was meeting its stated aims, but rather how it was doing so, what the barriers to successful implementation might be, and what are the strengths of the programme. This approach is valuable in terms of:

1. Informing future commissioning or design of interventions;
2. Understanding the contextual factors that influence success of an intervention;
3. Lobbying for resources to meet unmet needs identified;
4. Facilitating future, rigorous impact assessments;
5. Identifying promising (or best) practice for duplication and scale-up.
Key external stakeholders were in agreement that organisations derived from the MSM community, led by individuals who considered themselves MSM (or used a synonymous identity) were best placed to deliver interventions to the community. The SHARP partners have demonstrated they have the trust of large sections of the community and consistently extended their reach within challenging and often extremely hostile environments.

In exceeding its initial target of 8,280 MSM, SHARP has demonstrated success in reaching MSM between the ages of 20 and 30. Within such hostile environments, the fact that the partner CBOs have provided HIV prevention and care interventions to MSM is a considerable achievement. However, problems still remain in reaching men beyond the age of 30. While all contributors recognised that same sex activity continues beyond this age, societal pressures often make it harder for such men to engage with MSM CBOs. It is also the case that peer educators in most CBOs are under the age of 30 and when reach is often developed via the personal networks of these educators, engaging older men may remain a challenge. However, it is worth considering the age distribution of SHARP intervention recipients in relation to the current demography of the nations as a whole. Those aged 15-34 account for 35.4% of the population of Kenya\(^1\), 33.23% in Tanzania\(^2\), 35.67% in Zimbabwe\(^3\) and 21.2% of those aged 15-24 in Uganda\(^4\). With between 40% and 50% of males in each country being below the age of 15, SHARP can therefore be seen to reach a significant proportion of the sexually active population.

CBOs recognise that HIV positive MSM are coping with stigma and discrimination on the basis of both their sexual orientation and their HIV status. This has meant that fear of disclosure is often extremely high amongst these men, making the delivery of services and support for this population particularly challenging, even when the need is acknowledged to be great.

Different views are held as to the extent to which CBOs have been able to engage men across the spectrum of economic status. Concern is held by some external stakeholders (particularly those in Uganda and Tanzania) that interventions over-serve men in middle-income settings, although this is strongly disputed by the CBOs themselves.

CBOs’ geographic reach and saturation level varies. While many have either developed or are planning strategies to provide support to men outside of specific neighbourhoods, large towns or capital cities, there are likely many MSM still in need of services who do not have access.

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\(^3\) Zimbabwe censes 2012 national report. Zimstat, Harare.

1.2.2 Security, safety and social context

- While sex between men remains illegal in each country, the security of MSM CBOs, their staff, volunteers and clients is of paramount concern. Several SHARP CBOs have had to temporarily close, relocate or temporarily scale down or suspend services as a result of hostile social or political environments. The impact of this situation cannot be overestimated, threatening the continuity of services and posing the single greatest challenge to delivery of targeted HIV prevention, treatment and care interventions for MSM.
- The prevailing social and political situation significantly curtails the range of activities that are safe and permissible. Typical mass media approaches are non-viable and much outreach activity has to occur in a secret or non-visible manner.

1.2.3 Resilience and innovation

- Despite those security and safety concerns highlighted above, SHARP CBOs have demonstrated considerable resilience and ability to adapt and devised a number of innovative interventions to ensure continued engagement with their target population(s).
- CBOs have been early adopters of new smartphone technologies to engage MSM and extend the reach of their programmes. Facebook and WhatsApp are commonly used to make initial contact with MSM, prior to face-to-face information and advice interventions. While social media has potential for reaching MSM, it can involve a significant investment of staff time, at least initially. GALZ and IBU have also experienced security threats as a result of their online presence. There is currently very limited research to inform how best to position interventions within these spaces, and monitoring and evaluation of interventions delivered in online spaces remains complex.
- SMUG and MAAYGO have managed to develop innovative partnerships to allow radio broadcasts that seek to advance men’s understanding of their health and human rights, as well as broader HIV education for MSM. A significant investment of time was required in each case to sensitise the media outlets as to the needs of MSM, but this good practice can be shared across the region.

1.2.4 Partnerships and multi-sectoral programming

- Recognising extensive need and limited resources, SHARP CBOs have established partnerships with a number of other organisations to advance the health and social care needs of MSM and to extend their geographical coverage. Nearly all have established referral pathways for men seeking a HIV test, or for those who have been diagnosed with HIV. Onward referrals are also typically made to other social care and legal support organisations, although further partnerships might also be made in the future with housing, poverty, employment or nutrition organisations. However, partnerships can also be vulnerable to changes in the volatile political context and require significant ongoing investment of time to maintain.
- A clear SHARP work strand relating to sensitisation training of healthcare workers, the media and police helps to ensure longevity of impact and continued safer environments for MSM seeking services.
- With changes in global discourse and an increasing focus on key populations, more organisations in each country are claiming to deliver services for MSM. Many of these are not MSM-led and do not often have links with the MSM communities, but can result in service duplication and in resources being diverted away from those that do.
1.2.5 Holistic and enabling environments

- Several SHARP CBOs (especially MAAGO) had delivered a strategic approach to intervention delivery that emphasises holistic sexual health and well-being, as opposed to a focus on disease prevention and treatment. Research from multiple country contexts indicates this is a more effective approach, particularly in terms of maintaining engagement with MSM over longer periods of time.

- All CBOs recognised the wider social and economic circumstances of their target population, but were limited in how they could address concerns such as poverty, which were often drivers of sexual risk behaviour (e.g. sex work and transactional sex).

- While monitoring data of the programme indicates success and acceptability of SHARP activities focussed on HIV prevention and care, CBO staff expressed concern that many sections of the MSM communities have come to expect more from them than they are able to offer. As there are few organisations set up to address health and human rights concerns of MSM it is perhaps unsurprising that they anticipate a broader range of services and help to be available than can be catered for in a programme focussed on HIV.

1.2.6 Training, resource and organisational capacity

- The community systems strengthening components of SHARP have helped to improve organisational financial accounting, human resources, security, programme design and provided a strong basis for increased programming capacity and further development of funding.

- Adequate training of the CBO workforce, especially peer educators, remains a significant concern, as does retention of staff with requisite skills and experience.

- In each country there remain significant barriers to promotion of safer sex behaviours simply because of severely limited access to appropriate resources. Water based lubricant, an essential component of anal intercourse with condoms, is extremely difficult to source in each country. Additionally, there are barriers to both the design and distribution of tailored ICT materials that address sex between men, written in languages that are accessible to the target population.

1.3 RECOMMENDATIONS

In Chapter 8 we look to the future and make recommendations for delivery of HIV prevention and care interventions for MSM. In that chapter we contextually and fully describe each recommendation, but these are also summarised below.

1.3.1 Recommendations for individual level interventions

- There are considerable barriers to engaging MSM over the age of 30 but doing so should be considered a priority for future intervention planning.

- Given the rising use of mobile phone technologies, funders might consider the resourcing of short videos or pod-casts that could either be downloaded independently by MSM, or could be used by outreach workers to illustrate or describe HIV or STI prevention information.

- There remain unmet CBO training needs and, as is seen in many other settings that rely on volunteer peer educators, longer-term contribution to the programme can be difficult to balance with the need to earn a living.

- While the prevention of HIV is the key goal, interventions that do while attending to the broader dimensions of sexual health, satisfaction and pleasure may be more effective.
• Where resources allow, CBOs should consider advocacy for a broader range of condoms (and lubricant) to MSM.
• With exponential growth of mobile technology and smart phone coverage within Eastern and Southern Africa, interventions with marginalised communities conducted online have become a real possibility and should be prioritised for development.
• While there have been significant calls for funding of economic empowerment interventions for MSM (especially those who sell sex), caution should be exercised in resourcing such work without further research to establish efficacy.

1.3.2 Recommendations for community & structural level interventions
• CBOs should seek to capitalise on the increasing recognition of the importance of key populations within the HIV prevention, treatment and care sector. Emphasising their roots within the MSM community, and their MSM leadership is central to this.
• CBOs should be supported in increasing their efforts to utilise research to make arguments about the importance of providing for the health needs of MSM.
• The SHARP programme, and individual CBOs, may wish to consider the extent to which the advocacy functions of the CBO versus the service provision aspects of the CBO are compatible.

1.3.3 Recommendations for service level interventions
• Consideration should be given to expand the current programme of sensitisation training to other social care organisations in each country.
• Developing service level agreements (SLAs) could help to clarify expectations for both parties, provide a mechanism for addressing problems, smooth problems arising from changes in personnel and help to avoid tokenistic inclusion of MSM CBOs in projects when politically expedient.
• CBOs could derive additional benefit from their clinic/service-provider monitoring activities by establishing an accreditation scheme
• As CBOs are reviewing their ICT engagement, they could consider incorporating tools for men to look up recommended service providers and to rate them according to their experience
• Collaboration with medical schools and other professional training academies is another long-term approach to improving the service provision to MSM.
• The success of all of these suggested intervention developments will be contingent upon continued support for organisational development and capacity building.
2. BACKGROUND

Men who have sex with men (MSM) in sub-Saharan Africa, including in SHARP countries, have been neglected in epidemiological and public health research. While the knowledge base has been growing over the last 5 years, there remains relatively little information about basic epidemiological characteristics of HIV among MSM, including the percentage of men living with HIV (prevalence); the rate of new infections (incidence); size of the MSM populations; and on key indicators of the ‘HIV care cascade’ specifying the proportion of men who are regularly able to access testing, care services and antiretroviral therapy (ART) and those who are virologically suppressed. These figures are critical for informing prevention, treatment and care strategies, both for practical planning and implementation, and for the purposes of generating recognition of the gaps and issues in relation to HIV and sexual health needs of MSM. Research and programming has been hindered by the repressive and often violent political and social climate for MSM. To set the scene for making recommendations, we review here what is known about HIV epidemics among MSM in SHARP countries, and the political environment in which activities must take place.
2.1 EPIDEMIOLOGY

Among SHARP countries, there has been more research conducted among MSM in Kenya, and this has been based primarily in Mombasa and Nairobi, with smaller studies in Kilifi, Malindi and Kisumu. HIV prevalence estimates among MSM in Kenya have ranged from 12.3% to 43.0%. These higher estimates were from a high-risk cohort of men, with the higher amongst men who had sex with men exclusively, and the lower those who also slept with women. Male sex workers in Nairobi were also found to have a higher HIV prevalence than other MSM at 26.3% compared to 12.2%. For comparison, the prevalence of HIV amongst all men in urban settings in Kenya was 5.1% in 2012.

There has only been one HIV prevalence survey conducted amongst MSM in Uganda, which found among men enrolled from 2008-2009 that 13.7% (95% CI 7.9%-20.1%) were HIV positive, compared to 6.3% of the general urban population of Ugandan men. The majority of men surveyed were between 21 and 29 years old, and those aged over 25 had a higher prevalence, estimated at 22.4%. The homophobic legal and societal situation for MSM in Uganda (more on which below) has made research particularly challenging and even the cited situation for MSM in Zimbabwe have previously faced harassment and intimidation, and this political situation is described in more detail below.

The only estimates of HIV incidence from the SHARP countries come from Kenya. Estimates of the rate at which new MSM in Kenya become infected have ranged from 6.8 to 10.9 men per 100 person years, the upper estimate being amongst male sex workers in Nairobi. One study examining men who had sex exclusively with men separately found incidence of 35.2.

MSM have different identities, motivations and types of relationships, which should be reflected in tailored prevention efforts. For example, a study in Dar es Salaam has found that men engaged in transactional sex and sex work were more likely to use condoms and have higher numbers of both male and female partners, while men who reported that they sought love/affection were less likely to request or use condoms or lubricant. In SHARP country locations, MSM have additional vulnerabilities including substance use, injecting drug use and engagement in sex work. For example, in Zanzibar (part of Tanzania but technically not part of the SHARP programme), among a sample of 509 MSM, 14% reported injecting drugs in the previous 3 months and these men were more likely to be HIV positive and to be co-infected with Hepatitis C virus. Unexpectedly, however, men in one study in Kampala who reported illicit drug use were actually less likely to be infected with HIV than men who did not. Intersections of risk are likely to vary across different locations and will require tailored approaches.

Reported condom use by MSM in SHARP countries varies. According to the baseline needs assessment report of the SHARP programme, 57% of MSM in Kenya reported condom use every time they have sex, compared to 51% in Zimbabwe and 28.8% in Tanzania. Previous research shows a variety of possible reasons for this, including a lack of knowledge that anal sex without a condom can lead to HIV transmission, particularly given the mainstream focus on vaginal sex. While some MSM in Kampala have reported difficulty discussing condom use, a survey of men in Dar es Salaam reported little difficulty with this, though only 49% reported using a condom at last sex with last causal partner and 43% in sexual behaviours that could put them at a higher risk of HIV.

There is evidence that the prevalence of other sexually transmitted infections (STIs) is also high in the region. A study of men in Kampala from 2008-9 found that 12.4% (95% CI 8.2-17.8) had non-HIV STI infections. A study from Nairobi in 2010 found that among men who sometimes sold sex, 15% (95% CI 8.5-22.1) were infected with syphilis, chlamydia and/or gonorrhoea, while among men who did not sell sex, STI prevalence was estimated to be 5.3% (1.6-10.6). In Dar es Salaam, research has highlighted the need for awareness and access to treatment for anogenital STIs, with 26 of 180 men (14.4%) testing positive for rectal gonorrhoea and 23 testing positive for rectal chlamydia (12.8%).

2.2 HIV AND SEXUAL HEALTH NEEDS

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Homosexuality is criminalised in all of the SHARP countries, though both the means in which this is expressed legally and the extent to which it is enforced in practice varies. In Kenya, there are prison sentences of up to 14 years for participating in same-sex relationships. In mainland Tanzania, the laws that are usually applied to MSM include one dating to the colonial period prohibiting ‘gross indecency’, carrying a sentence of up to 5 years, and one interpreted to prohibit anal sex, which in theory does also apply to heterosexual sex, carrying a sentence of up to 30 years imprisonment. Non-heterosexual identities are not well accepted by society. In Zimbabwe, homosexual activity is punishable by one year in prison and its’ LGBT organisations are regularly persecuted by state actors.35

While the existing research on MSM in SHARP countries does point to areas of need, the numbers of studies for this highly at risk population is still small and the full diversity of the MSM population and thus their specific needs not captured. The research that exists on MSM describes HIV prevalence much higher than in comparable men from the population in general. The estimated rates of new infections from Kenya are extremely high, particularly amongst men who exclusively have male sexual partners. There is little known, however, about the prospects for men who have been infected, their entry and engagement in the HIV care cascade, their access and adherence to ART and their survival. In certain settings, notably in Zimbabwe and only to a slightly lesser extent in Uganda, there are information black holes, a situation that needs to be rectified but is exacerbated by the political and policy context described below.

2.3 LEGAL SITUATION, ABUSE AND DISCRIMINATION

Homosexuality is criminalised in all of the SHARP countries, though both the means in which this is expressed legally and the extent to which it is enforced in practice varies. In Kenya, there are prison sentences of up to 14 years for participating in same-sex relationships. In mainland Tanzania, the laws that are usually applied to MSM include one dating to the colonial period prohibiting ‘gross indecency’, carrying a sentence of up to 5 years, and one interpreted to prohibit anal sex, which in theory does also apply to heterosexual sex, carrying a sentence of up to 30 years imprisonment. Non-heterosexual identities are not well accepted by society. In Zimbabwe, homosexual activity is punishable by one year in prison and its’ LGBT organisations are regularly persecuted by state actors.35

Similar to other countries previously under British colonial rule, Uganda has a clause in its criminal code that has been interpreted to criminalise homosexuality. However, this situation was exacerbated in early 2014 when the ‘Anti Homosexuality Act’ was passed, which included heavier penalties and clauses criminalising individuals for providing housing and work and for not reporting

31 Magesa, D.J., et al., Barriers to men who have sex with men attending HIV related health services in Dar es Salaam, Tanzania. Tanzanian Journal of Health Research, 2014. 16(2).
‘known homosexuals’. The Act, originally introduced in 2009 and a precursor to a period of growing hostility and violence towards LGBT people in Uganda, had widespread negative consequences for the sexual health and rights promotion of MSM in Uganda. The Act was struck down later in 2014, but this judgement rested upon a technicality rather than a shift in political or public opinion. As well as making existing penalties harsher (including 14 year sentences for ‘homosexual acts’ and lifetime sentences in ‘aggravated’ cases including where the accused person was HIV positive) the Act included prison sentences for not reporting LGBT individuals to authorities, seriously jeopardising the social relationship, access to healthcare and ability to organise supportive and health-promoting activities. The political climate surrounding the bill has also been associated with violence and harassment of Uganda’s LGBT community.

Having either explicitly or implicitly denied the existence of LGBT populations, SHARP countries have been slow to include MSM in national strategic planning to address the HIV epidemic, and in the case of Zimbabwe, characterised them as a threat to public health. Coupled with widespread societal condemnation of homosexuality, as well as general stigma related to HIV, the situation has meant that MSM in SHARP countries have been very much underserved in their access to HIV prevention, treatment and care, and sexual health and rights more broadly. Uganda’s recent legal escalations against LGBT population, discussed further below, have inflamed the political situation in other countries as well, with MPs attempting in Kenya and Tanzania, albeit unsuccessfully, to introduce similar bills.

Surveys show very low acceptance of homosexuality amongst the general public in sub-Saharan African countries, with 96% in Uganda and 90% in Kenya responding ‘no’ in 2013 in response to the question ‘should society accept homosexuality?’. In contrast to many countries with high overall acceptance of homosexuality, young people in these two countries were more likely to be accepting than those in older age groups.

Anti-homosexuality laws ferment homophobia and encourage an environment that facilitates intimidation and abuse of MSM by authorities and members of the public. In a sample of 200 MSM recruited in Dar es Salaam, 29.5% reported having ever experienced physical abuse, 48.5% verbal abuse, 32.5% moral abuse and 30% sexual abuse. A Human Rights Watch investigation in Tanzania that interviewed 47 MSM and additional key informants reported extortion, physical and sexual violence from police and members of the public. Those of lower socioeconomic status and those engaged in sex work tended to be most vulnerable to abuse. During 2012/13 Gays and Lesbians of Zimbabwe (GALZ) collected and verified 49 cases of assault, threats, outing, detention, discrimination, disownment, hate speech, invasion of privacy, police harassment and blackmail on the basis of sexual orientation or perceived orientation.

Some of these cases occurred in healthcare facilities, some following attendance at LGBT events and one notably at the GALZ office itself, indications of the challenges facing sexual health and rights promotion in Zimbabwe. A recent report from Uganda documents a range human rights violations perpetrated on sexual minorities within the criminal justice system, including forced medical examinations (with no scientific merit), in-cell abuse, media parading of LGBT victims, and use of criminal charges for extortion and blackmail.

There is evidence from some surveys of MSM, though not in others, that individuals who have experienced abuse are more likely to be HIV positive. In Kampala, men who had ever experienced homophobic abuse had 5.4 times the odds of being HIV positive compared to men who had not, and a survey in Dar es Salaam found evidence that experiencing verbal abuse was associated with being HIV positive. It is challenging to conduct research in locations where men are actively persecuted, due to the prohibitive legal environment and a fear of disclosure. However, the fact that many men report fear of accessing health services, that there is limited access to protective materials such as condoms and lubricants and that health promotion organisations are actively persecuted suggests that the legal and social discrimination against LGBT people are structural drivers of HIV risk.

20 Where do we go for justice: The abuse of rights of sexual minorities in Uganda’s criminal justice system. 2015, Chapter Four: Kampala, Uganda.
In addition to abuses suffered by individual MSM, the legal, political and social climate also hampers efforts to engage men in HIV prevention, treatment and care, and specific incidents can have lasting detrimental effects. Reports of violence against individuals include those who were trying to conduct health promotion activities. Research into the aftermath of the arrests of HIV prevention workers in Senegal found that many services closed out of fear, men went into hiding and participation in programme reduced significantly.

At the same time, certain ministries of health in sub-Saharan Africa (including Ghana, Mozambique, South Africa and Tanzania) have made steps towards establishing contact with MSM organisations, recognising the needs for programming and making improvements to policy frameworks. In Tanzania, MSM have been mentioned in the 2013/14-2017/18 national plan. While the plan does not specify in much detail how MSM HIV prevention, treatment and care will be implemented, it does hopefully represent a step forwards.

### 2.4 REGIONAL INTERVENTIONS

There has been little published research on what approaches to promoting sexual health amongst MSM in sub-Saharan Africa are most successful. Exposure to a peer education and outreach programme was found to be associated with increased consistent condom use, use of water-based lubricant and improvements in HIV knowledge among male sex workers in Mombasa. Studies amongst healthcare workers in Kenya find that there is currently inadequate training and sensitisation to the needs of MSM patients, but that sensitisation interventions can improve knowledge and self-reported homophobia.

A report from a 2011 workshop of MSM organisations from 17 African countries, categorised and prioritised HIV care and prevention needs under the following headings: structural, behavioural and biomedical. Under structural interventions, participants listed healthcare worker training, improved social capital and community capacity building. For behavioural interventions, three types of counselling were prioritised: adherence counselling, risk reduction and mental health counselling. In terms of biomedical interventions, participants expressed a need for more research into the potential for rectal

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42 Avrett, S., Human Rights Considerations in Addressing HIV among Men Who Have Sex with Men, in AIDSTAR-One. 2011: Arlington, VA, USA.
This appraisal does not constitute a programme impact assessment. The ultimate goal was not to assess whether the programme was meeting its stated aims, but rather how it was doing so, what the barriers to successful implementation might be, and what are the strengths of the programme. This approach is valuable in terms of:

1. Informing future commissioning or design of interventions;
2. Understanding the contextual factors that influence success of an intervention;
3. Lobbying for resources to meet unmet needs identified;
4. Facilitating future, rigorous impact assessments;
5. Identifying promising (or best) practice for duplication and scale-up.

There is an urgent need to improve our understanding of how to address the sexual health and rights of MSM in SHARP countries. A first step towards generating this evidence is to understand, from the perspectives of MSM organisations in SHARP countries, what interventions are currently being implemented, how they are conceptualised in terms of their aims and objectives, what kinds of challenges they face in implementing programmes and how they have addressed these challenges. While the situation for MSM across and within SHARP countries is variable, it is likely these organisations could benefit from the approaches being taken in neighbouring countries. This project represents an approach towards collecting this evidence, through documenting current approaches, challenges and successes.

2.5 AIMS

The specific objectives of this project were, therefore, as follows:

**Aim:** To review and appraise existing attempts to engage MSM in HIV and human rights based interventions across SHARP programme countries

**Objective 1:** Describe and map the range of existing interventions and methods to engage MSM (achieving breadth)

**Objective 2:** Establish the aims and intended change in the target population of selected interventions (achieving depth)

**Objective 3:** Appraise the effectiveness of these selected interventions against their stated aims by devising and utilising a standardised assessment tool

**Objective 4:** Identify and describe best practice in engaging MSM according to intervention type

**Objective 5:** Make recommendations for the scale-up of interventions in the next phase of the SHARP programme.

microbicides and Pre-exposure Prophylaxis, and a need for condoms and water-based lubricants. These suggestions do reflect the findings from existing surveys of MSM, though the means by which such approaches can be implemented are as yet undocumented.
3. METHODOLOGY
3.1 OVERALL APPROACH

This project has conducted, in collaboration with and on behalf of the International HIV/AIDS Alliance, a detailed mapping and appraisal of existing HIV prevention, treatment and care interventions that target MSM in Kenya, Tanzania, Uganda and Zimbabwe. We have described the range of existing interventions and then explored three or four interventions per implementing partner in greater depth. All SHARP collaborating organisations seek to engage men in such interventions, although they differ significantly in their approach, aims, methods and effectiveness. There have been many attempts to engage MSM for these interventions in both physical and online environments, although we currently lack a comprehensive understanding how these interventions operate and perform. There are also several organisations that target MSM for HIV prevention, treatment and care interventions who currently fall outside of the programme but who have valuable experience and good practice that can be identified and disseminated across the region.

Appraisals such as this are a necessary first step to defining programme descriptions, logic models and key questions to inform a later, more comprehensive evaluation that can investigate programme impacts. During this largely reflective stage, programme goals are agreed upon, the information needs of implementers are defined, and the potential data obtainable for evaluation is considered.

We developed a set of tools and templates to collect the information outlined under each objective during country visits between September and November 2014. We spent roughly 3 full days with each SHARP organisation, and held meetings with the Alliance country Linking Organisations, other key stakeholders and MSM organisations where available. We describe the approach taken for each of our specific objectives below.

3.2 METHODS OF ADDRESSING OBJECTIVES 1 & 2

Mapping and description of interventions AND Establishment of aims and expected change in target population of each intervention type.

We took two approaches to mapping interventions: a comprehensive intervention description approach for SHARP implementing partners; as well as top-level mapping and information gathering from non-SHARP organisations working to support MSM in the region. Table 3.1 describes the SHARP partner organisations who participated, their locations and the job roles of the staff we interviewed.

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We also reached out to local contacts to facilitate introductions with non-SHARP organisations and spoke with a large number of other MSM CBOs, local academics, clinical service providers (who engage with MSM), and

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**TABLE 3.1 SHARP partner organisations who participated in the project**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Main services provided by organisation</th>
<th>Role of individuals interviewed</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHESA1 Community Health Education Services &amp; Advocacy</td>
<td>Outreach and resource distribution; peer support; mobile HIV counselling &amp; testing (HTC); drop-in centre; health service referrals; sensitisation training; advocacy</td>
<td>Director, programme capacity-building officers, peer educators, those responsible for M&amp;E</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>SANA1: Stay Awake Network Activities</td>
<td>Outreach; peer support; mobile HIV counselling &amp; testing (HTC); drop-in centre with HTC; health service referrals; sensitisation training; advocacy</td>
<td>Director, capacity-building officers, peer educators, nurse counsellor</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>TACOSODE2: Tanzania Council for Social Development</td>
<td>Programme coordination; community systems strengthening; lobbying and advocacy</td>
<td>Programme manager, programme officer</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>GALZ1: Gays &amp; Lesbians of Zimbabwe</td>
<td>MSM community mobilisation (online and offline); outreach and resource distribution; health service referrals; legal services referrals; social events; counselling; sensitisation training; advocacy</td>
<td>Director, programmes officer, other staff members</td>
<td>Harare, Zimbabwe</td>
</tr>
<tr>
<td>ISHTAR MSM1</td>
<td>Outreach and resource distribution; peer support; drop-in centre with HTC and STI syndromic screening; health service referrals; sensitisation training; social events</td>
<td>Director, programmes manager, finance manager, nurse, peer educators</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>MAAYGO1: Men against AIDS Youth Organisation</td>
<td>Outreach and resource distribution; peer support; drop-in centre; health service referrals; sensitisation training; social events</td>
<td>Director, programmes manager, finance manager, peer educators</td>
<td>Kisumu, Kenya</td>
</tr>
<tr>
<td>KANCO1: Kenya AIDS NGOs Consortium</td>
<td>Programme coordination; community systems strengthening; lobbying and advocacy</td>
<td>Programme manager, programme officer, M&amp;E manager</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>CHAU: Community Health Alliance Uganda</td>
<td>Programme coordination; community systems strengthening; lobbying and advocacy</td>
<td>Programme director</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>IBU1: Icebreakers Uganda</td>
<td>Outreach with HTC and STI screening and resource distribution; community mobilisation; peer education and support; drop-in centre and outreach clinic; health service referrals; sensitisation training;</td>
<td>Director, programmes manager, programmes officer, peer educators</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>SMUG1: Sexual Minorities of Uganda</td>
<td>Emergency crisis response; legal services; radio broadcasts; lobbying and advocacy for MSM</td>
<td>Director, programmes manager, programmes officer</td>
<td>Kampala, Uganda</td>
</tr>
</tbody>
</table>

1 = SHARP Implementing partner MSM CBO;  
2 = SHARP linking organisation (a local partner within the International HIV/AIDS Alliance)
TABLE 3.2: External organisations or individuals who participated in the project

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Type of organisation</th>
<th>Role of individuals interviewed</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASADA: Pastoral Activities and Services for people with AIDS Dar es Salaam Archdiocese</td>
<td>HIV/AIDS testing and care clinic</td>
<td>Director, Medical Director and doctor.</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>Muhimbili University of Health and Allied Science</td>
<td>University and hospital</td>
<td>Professor, involved in previous research with MSM in Dar es Salaam.</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>TAPP: Tanzania AIDS Prevention Programme</td>
<td>Primarily a service for people who inject drugs but also works with SANA and CHESA to provide a mobile testing caravan for MSM in sites around Dar es Salam</td>
<td>Lead staff member for work with MSM.</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>THPS: Tanzania Health Promotion Support</td>
<td>NGO previously working with key populations in Zanzibar, moving into work on the mainland too</td>
<td>Director</td>
<td>Dar es Salaam, Tanzania</td>
</tr>
<tr>
<td>IAVI: International AIDS Vaccine Initiative</td>
<td>NGO working to advance vaccine development and community capacity</td>
<td>Programme manager</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>HOYMAS</td>
<td>CBO serving male sex workers, other MSM and men living with HIV</td>
<td>Director</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>LVCT: Liverpool Voluntary Counselling &amp; Testing</td>
<td>HIV voluntary counselling, testing and care provider</td>
<td>MARPs coordinator, head of research</td>
<td>Nairobi &amp; Kisumu, Kenya</td>
</tr>
<tr>
<td>GALCK: Gay &amp; Lesbian coalition of Kenya</td>
<td>A national coalition of organisations working to improve the lives of LBGT people in Kenya</td>
<td>Director</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>NYARWEK</td>
<td>A regional coalition of organisations working to improve lives of LGBT people in Western Kenya</td>
<td>Human rights coordinator</td>
<td>Kisumu, Kenya</td>
</tr>
<tr>
<td>Partners for Health and Development in Africa</td>
<td>A local office of the University of Manitoba, who run a sex workers outreach project and provide technical assistance to Ministry of Health</td>
<td>Head of technical support, senior technical advisor</td>
<td>Nairobi, Kenya</td>
</tr>
<tr>
<td>Youth on Rock</td>
<td>An MSM support group for younger men from poorer districts of Kampala</td>
<td>Director, head of communications</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>MARPI: Most at risk populations initiative</td>
<td>A state sanctioned clinic that provides HIV testing and treatment, as well as STI screening. Works in partnership with IBU</td>
<td>Doctor, head of engagement</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>COPTEC: Come out post-test club</td>
<td>Support group for transgender men with diagnosed HIV</td>
<td>Director</td>
<td>Kampala, Uganda</td>
</tr>
<tr>
<td>Spectrum Initiatives</td>
<td>CBO delivering outreach type interventions to older MSM</td>
<td>Director, head of programmes</td>
<td>Kampala, Uganda</td>
</tr>
</tbody>
</table>
To initiate our detailed data collection with SHARP partners, staff and volunteers were gathered together to participate in a group exercise to map all of their interventions and their relationships with each other.

Because outreach to MSM is a key component of SHARP activities and the one on which other activities are predicated, we began here, as in the example given in Figure 1.

**FIGURE 1 Example intervention process grid**

In collaboration with the CBO, and with prior input from the International HIV/AIDS Alliance, we then identified several (2-4) interventions for each organisation to focus on in detail. We sought to strike a balance between core activities and particularly unique or innovative interventions. A full list of interventions selected for inclusion can be found in Appendix A.

We then conducted interviews with appropriate staff and volunteers to collect information about each of these chosen interventions. To ensure that we used a common language across SHARP partners, we adapted and developed an ‘MASTOR’ intervention mapping tool (see Table 3.3). MASTORS have commonly been used for mapping HIV prevention activity in the UK.\(^{51}\)

**TABLE 3.3 MASTOR used for collecting descriptions of each SHARP intervention**

<table>
<thead>
<tr>
<th>Mission/Meta Aim</th>
<th>Aim (and outcomes)</th>
<th>Outcome indicator</th>
<th>Evaluation description</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is intended to be changed at a meta or programme level?</td>
<td>What is intended to be changed?</td>
<td>How is the change measured?</td>
<td>What methods are being used to measure the outcome indicators?</td>
</tr>
<tr>
<td></td>
<td>What is the tangible result of having undertaken the intervention?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting</th>
<th>Target group</th>
<th>Objectives (and outputs)</th>
<th>Output indicator</th>
<th>Monitoring description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where does it take place?</td>
<td>Among whom is the proposed change intended to occur?</td>
<td>What does the intervention consist of? What are the tangible activities that are undertaken to achieve the outcome?</td>
<td>What is the level of activity being undertaken?</td>
<td>What methods are being used to measure the output indicators?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What human and financial resources are needed?</td>
<td></td>
</tr>
</tbody>
</table>

Objective 3: Rapidly appraise the effectiveness of interventions &
Objective 4: Identify and describe best practice in engaging MSM according to intervention type.

The tool we used for rapid appraisal of interventions is given in Table 3.4, which includes the ‘qualities of an intervention’ criteria outlined in ‘Making It Count’51. Making It Count is a tool developed for planning interventions to reduce HIV amongst men who have sex with men, and has been developed and revised in collaboration with a wide range of stakeholders (practitioners, researchers, healthcare authorities and policy-makers).

### TABLE 3.4 Qualities of an intervention considered during appraisal

<table>
<thead>
<tr>
<th>Appraisal Dimensions</th>
<th>Criteria by which the intervention is assessed</th>
<th>Elements of MASTOR and Logic Pathways to reference and reflect upon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feasibility:</td>
<td>Has it been possible to deliver the intervention as intended? What have been the obstacles? Has there been a need for changes to the intervention based on these obstacles? What has facilitated the intervention?</td>
<td>MASTOR Objectives, MASTOR Output indicators</td>
</tr>
<tr>
<td>Cost:</td>
<td>Are you able to track the resources required for the intervention (staff, volunteers, equipment)? Have these been adequate? Have you needed to adapt the budget you originally planned?</td>
<td>MASTOR Resources</td>
</tr>
<tr>
<td>Acceptability:</td>
<td>Is the intervention welcomed by the community of MSM? Sections of the community? By other partners required to make to intervention happen? (E.g. health services)? The population in general?</td>
<td>MASTOR Output indicators, MASTOR Objectives</td>
</tr>
<tr>
<td>Coverage and access:</td>
<td>Who, of the target population, is the intervention reaching and who is missed out? What are the consequences of this for equity? What currently impedes access to those currently missed out? Is the target group appropriate/feasible?</td>
<td>MASTOR Target Group, MASTOR Setting, MASTOR Output indicators</td>
</tr>
<tr>
<td>Needed:</td>
<td>Do the aims of the intervention align with the needs of the community? Are there unmet needs from current interventions (or ‘gaps’)?</td>
<td>Logical framework, MASTOR Objectives, MASTOR Target group</td>
</tr>
<tr>
<td>Effectiveness:</td>
<td>Does the intervention meet its objectives? Does meeting these objectives result in a change in outcomes?</td>
<td>MASTOR Objectives, MASTOR Aims, MASTOR Meta-aim</td>
</tr>
<tr>
<td>Efficiency:</td>
<td>Given the costs of the intervention, and the extent to which you believe it achieves aims and meets the needs of the community, would you say that it is efficient? If, given a finite amount of resources, you were going to continue or scale-up an intervention, how would this intervention and its activities compare to others you do?</td>
<td>MASTOR Aims, MASTOR Resources, MASTOR Needs</td>
</tr>
</tbody>
</table>
3.4 ANALYSIS OF DATA AND DEVELOPMENT OF RECOMMENDATIONS

The intervention mapping, descriptions and appraisals, as well interviews with SHARP organisation directors, Linking Organisations and non-SHARP actors thus provided the data we have used to generate recommendations and suggested directions for further evaluation. We categorised SHARP interventions according to the International HIV AIDS Alliance’s multilevel framework, distinguishing services delivered to individual MSM, to broader communities and to service providers. Within these categories, we discerned further intervention types. We examined interventions across the SHARP partners and countries, identifying commonalities and differences and drawing out case studies of particularly innovative practices.
SHARP partner organisations across all four countries deliver a range of interventions that are designed to address or meet the sexual health and psychosocial needs of men who have sex with men. They communicate directly with men whose behaviour puts them at risk of HIV exposure or transmission or who are experiencing (or at risk of) psychological distress or harm from their social environment. This is our meaning of individual level interventions.

We begin this chapter by describing the means of engaging MSM that CBOs employed. As individual level interventions comprise a significant proportion of work for CBOs, we have further sub-divided these and devised a setting specific-typology. This typology is then used as the framework for the remainder of this chapter, with aims and objectives and intervention appraisals linked to each of the five intervention types. This chapter closes by briefly examining evidence from evaluation or appraisal of interventions conducted with marginalised populations in other countries, and by making a series of recommendations that will be of relevance to CBOs, programme managers and funders. Throughout the chapter we present a series of case studies that show case innovative or promising practice by SHARP partners or other MSM CBOs.
SHARP partners, and other organisations, have devised a number of mechanisms by which they engage the population of MSM in their city or country. These are both reactive and proactive in nature, and there is evidence that all of CBOs have begun to make use of mobile technologies (such as smartphones and apps), to greater and lesser extents, to extend their reach.

4.1 ENGAGING MSM

Centre based drop-in or group services typically operate by allowing MSM to attend the centre or offices of the CBO to receive services from staff based there during opening hours. This may be on a one-to-one basis, or as part of a group workshop or training.

Broadcast media approaches to engaging MSM typically involve the use of Facebook or WhatsApp, or the use of commercial radio. All CBOs have Facebook group pages they utilise to build and maintain an online community of MSM, or use it to identify new potential clients (usually by tracking who has ‘liked’ MSM-friendly posts, or has made a friend request after such posts). WhatsApp is often utilised for group discussion or information exchange, or one-to-one contact. These latter, online approaches are often the precursor to physical outreach.

Outreach in bars and MSM hotspots involves peer educators visiting physical settings where MSM are known to congregate, such as bars, hotels or parks. In many instances, peer educators have made prior arrangements to meet MSM there, either by referral by text from an existing client, or as a result of interacting in online, social media spaces.

External events/parties are a proactive engagement method whereby CBOs establish a physical space where MSM (and perhaps other lesbian, bisexual or transgendered persons) can congregate. For example, a party held in a private venue that draws in MSM who can then be targeted for intervention.

FIGURE 4.1 Mechanism of engaging MSM among CBOs
CASE STUDY 1  CHESA & SANA: Hotspot mapping in neighborhoods of Dar es Salaam

CHESA and SANA primarily engage new clients through reaching out to them at physical venues in the neighborhoods they serve around the city. In order to do this, they have a map of locations where MSM are known to meet, including bars, music halls, beaches and private addresses. This 'hotspot map' – a large physical display on the wall – therefore underpins many of SANA and CHESA’s activities and is updated yearly.

Because of the repressive political and social environment, venues for where MSM live or meet shift quite rapidly. For the most part, there are not stable venues consistently catering to the MSM population. Thus an area where men congregate one year might no longer be a meeting point the next year. In order to update the map, SANA and CHESA first identify and then approach individuals at each location who can serve as ‘gateways’ to the community of MSM there. Peer educators arrange a time to visit these gateway individuals to ascertain whether there are still MSM present at the location. New hotpots are also identified through the social networks that staff and peer educators are a part of and from enquiring at each identified hotspot. The CBOs engage with local authorities to make them aware of their mapping activity, which helps to prevent problems. More informally, throughout the year peer educators might become aware of new locations to visit or locations that become inactive, and these changes are recorded. The map then forms the basis on which peer educator work is organised and the means by which the mobile caravan intervention is planned. Given the changing nature of the MSM physical venues, and where men feel safe to meet, it is necessary to update these maps on a regular basis, ideally at least every 2 years.

To date CHESA and SANA have conducted mappings in Ilala and Kinondoni in Dar Es Salaam and they plan to do mappings in Pwani and Tanga in 2015.

4.2 OVERVIEW OF EXISTING INTERVENTIONS

Once CBOs have engaged or identified MSM, there is a range of individual level interventions that they may employ. Many of these interventions are setting dependent.

• **1 to 1 information and advice** (page 32): typically offers individuals the opportunity to have a short discussion about sexual health needs and concerns, face-to-face. They are normally delivered as part of outreach activities by MSM organisations and their partners. This one-to-one advice can be delivered in physical locations, or online via social media.

• **Group information and advice** (page 38): typically provide information and/or skills training to groups of men on issues such as sexual health, relationships, human rights or personal safety. Generally conducted at offices of the MSM organisation, but can take place in external venues. Group interventions can take place in face-to-face settings or be facilitated via social media.

• **1 to 1 clinical interventions** (page 41): typically offer HIV counselling and testing, as well as HIV/STI screening and treatment. These can be delivered in fixed site clinics (e.g. at the CBO office) or be ‘mobile’ as part of outreach.

• **Broadcast and social media** (page 44): relates to information and advice that is broadcast to MSM via websites, social media, bulk text-message or WhatsApp chat group. Information provided may range from awareness raising of interventions (e.g. testing) or information about safer sex and obtaining condoms. Interventions within this category are typically unidirectional and non-interactive in nature.

• **Condom and lubricant distribution** (page 47): relates to the distribution of condoms and lubricants to the target population, either in fixed sites (such as at CBO drop in centres) or as part of outreach based interventions.
These interventions are often interlinked and can rely on one another to be feasible or effective. While described here separately, it is often the case that they run concurrently – e.g. information and advice around safer sex provided by a peer educator immediately prior to HIV testing or STI screening by a nurse or doctor. As outlined in section 3.2, outreach often provides the core of organisational activity and is the entry point through which other interventions are made possible. Some activities span all intervention types. For example, condoms and lubricant (where available) may be distributed 1 to 1 in outreach settings, in clinical settings and at group events.

Given that many of the issues relating to successful implementation of the interventions are determined by setting and the ability to ‘reach’ the population in such complex social and political circumstances, they frequently share a common set of strengths and weaknesses. These are outlined in section 4.3.1 but have a bearing on all other sections.

### 4.3 INTERVENTION APPRAISAL

#### 4.3.1 1 to 1 information and advice

These interventions typically constitute the largest component of work for most SHARP CBOs (with the exception of SMUG), and those external to the partnership who participated in this project. In total, 4356 MSM have been taken through health education in face-to-face settings by peer outreach workers since the programme began. An additional 1436 MSM have received health education from peer outreach workers in online environments, such as private messaging in social media. Designed to meet the basic information needs of MSM, they seek to educate men on issues that affect their sexual, psychological and social health or well-being. Aims and objectives of 1 to 1 information and advice are presented in Table 4.1.

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives (such as the following)</th>
</tr>
</thead>
</table>
| To increase men's knowledge about HIV, exposure to the virus and prevention of infection and transmission | An increased proportion of men are aware of high HIV prevalence among MSM  
An increased proportion of men understand how HIV is transmitted during sex  
An increased proportion of men understand the consequence of HIV infection for their health  
A increased proportion of men understand how effective condom use can prevent HIV transmission |
| To increase men's knowledge about the benefits of HIV testing and where to access a test | An increased proportion of understand how and where to take an HIV test  
An increased proportion of men understand how HIV treatments can improve or maintain health and well-being  
An increased proportion of men understand how HIV treatment, as secondary benefit, can reduce the likelihood of transmitting the virus if you are HIV positive |
<table>
<thead>
<tr>
<th>To increase men’s knowledge about STIs, their symptoms and prevention</th>
<th>An increased proportion of men understand the prevalence of STIs among MSM in their area.</th>
<th>An increased proportion of men can recognise the symptoms of certain STIs common among MSM.</th>
<th>An increased proportion of men understand how STIs can be avoided, by the effective use of condoms &amp; lubricants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase men’s knowledge about STI testing and where to access STI testing and treatment</td>
<td>An increased proportion of men understand how and where to receive STI screening.</td>
<td>An increased proportion of men understand the benefits of STI screening and treatment.</td>
<td></td>
</tr>
<tr>
<td>To increase men’s knowledge about where to access condoms and lubricant</td>
<td>An increased proportion of men understand where they can obtain free condoms and lubricant, and how to use them effectively.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To increase men’s knowledge about HIV treatments and how to access them</td>
<td>An increased proportion of men with diagnosed HIV understand how treatment works.</td>
<td>An increased proportion of men with diagnosed HIV know where they can access free treatment, free from discrimination.</td>
<td></td>
</tr>
<tr>
<td>To increase men’s knowledge of how to live well with HIV and services that support this</td>
<td>An increased proportion of men with diagnosed HIV understand the importance of HIV treatment adherence.</td>
<td>An increased proportion of men with diagnosed HIV understand the importance of careful nutrition.</td>
<td></td>
</tr>
<tr>
<td>To increase men’s knowledge of how to improve psychosocial well-being and services that support this</td>
<td>An increased proportion of men know who they can talk to in a neutral and non-judgemental manners about their feelings and experiences.</td>
<td>An increased proportion of men understand how they address feelings of internalised homonegativity and seronegativity.</td>
<td></td>
</tr>
<tr>
<td>To increase men’s knowledge of how to build (healthy) relationships</td>
<td>An increased proportion of men know how to reflect on what they want from a meaningful relationship with other men.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To increase men’s knowledge and awareness of their human and legal rights</td>
<td>An increased proportion of men are aware of where they can access MSM friendly health services.</td>
<td>An increased proportion of men are aware of the legal right to health for MSM (in line with all citizens).</td>
<td>An increased proportion of men are aware of their legal rights and how to report homophobic attacks.</td>
</tr>
</tbody>
</table>
**Strengths**

- **Trust from the community.** SHARP partner CBOs are MSM led organisations that, in general, appear to have the trust of their local MSM populations. This is evidenced by the number of MSM in receipt of intervention and the fact that many other organisations and state-facilitated services (e.g. LVCT in Kenya; MARPI in Uganda) rely on the CBOs to mobilise MSM to attend their clinics.

- **Community understanding.** The CBOs appear to possess crucial information about the nature of the communities they seek to serve, evidenced by their understanding and mapping of hotspots and the sensitive and safe manner in which they approach new members or service users.

- **Control of adverse events.** There have been few reported adverse incidents in the delivery of 1-to-1 information and advice sessions: despite the often volatile social and political circumstances, the CBOs have managed to deliver essential services largely without physical harm to themselves or their members/service users.

- **Accepting and non-judgemental.** All SHARP CBOs adopt a principle of openness and acceptance in their work, without judgement of clients or service users on the basis of their behaviour. A large number of MSM sell sex and access 1-to-1 information and advice interventions and, while efforts were made to empower such men with the skills to make money by other means, there no suggestion of judgement.

- **Client and service user confidentiality.** All staff and peer educators understand the paramount importance of ensuring the confidentiality of all clients and service users, especially those who are not ‘out’ as MSM. Most organisations have systems for ensuring control of information regarding an individual’s HIV status, and access to diagnosis information is typically restricted to the individual peer educator who work with them, the outreach manager and the resident clinician (if appropriate).

- **Reaching young MSM.** One of the key achievements of the SHARP programme is in reaching, and exceeding, its target of 8,000 MSM. With a total of 14,900 MSM reached as of December 2015, SHARP has succeeded in delivering targeted interventions to a marginalised community in a politically and socially hostile environment. A majority of such MSM (76%) are aged between 20 and 30, suggesting an effective model for accessing young MSM social networks – largely via social media and personal connections of the peer educator teams.

**Capacity for impact**

- **Regional outreach.** Most SHARP programme activity originated in the capital cities of each country, with the exception of Kisumu in Kenya (with interventions delivered by MAAYGO). Since the inception of the programme, significant effort has been made to extend the reach to additional towns and cities: GALZ has extended its portfolio of services to reach across 10 towns in Zimbabwe on a monthly basis; IBU conducts mobile outreach sessions across all regions of Uganda; while SANA and CHESA have extended their remit to outer districts of Dar es Salaam (and in the last 6 months, into the cities of Tanga and Pwani). In the case of Uganda and Tanzania, the extension of geographic reach by identifying and recruiting MSM

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**CASE STUDY 2  IBU: Using social media to engage MSM**

IBU in Kampala have rapidly adopted the use of social media and new mobile technologies to facilitate provision of 1 to 1 information and advice to a wider constituency of MSM. Initial contact is made with MSM (or men thought likely to be MSM) via sites such as Facebook. Peer educators post comments or pictures to their wall relating to sex or same sex attraction (such as a photo of an attractive man). When they receive “likes” of these posts, or when they receive friend requests following the posts, they investigate to establish how they are connected and make contact, explaining who they are and what role they perform for the SHARP partner organisation. They may provide information and advice in this contact but ultimately aim to establish face-to-face contact so they can be registered as programme recipients and receive condoms and lubricants (if required).
to act as peer educators in other towns and cities. Such individuals are identified through personal contacts or via social media. They are supported by the CBO located in city and helped to mobilise local MSM when mobile clinical services are brought to the area (see section 4.3.2), or to distribute information and protective equipment (condoms and lubricant). Such an approach ensures the service is grounded in the local community of MSM and can be responsive to their needs. GALZ in Zimbabwe and IBU in Uganda both have a formal structure for supporting new sites around the country, supporting groups of ‘buddies’ until they are large enough to have their own site coordinator.

• **Use of new technologies.** The practical constraints on safely providing MSM with 1-to-1 information and advice in physical settings (such as hotspots) has led many CBOs to invest significant time and resources engaging men online. This is especially the case with GALZ, ISHTAR, SMUG and SANA. While not without its own challenges (largely relating to access and display of information), using existing technologies popular with MSM, such as Facebook and WhatsApp, means they can engage a wider constituency of men than might otherwise have been the case. CBOs such as GALZ and ISHTAR have a detailed targeting strategy, whereby different Facebook groups are maintained to reach different groups of men.

• **Holistic sexual health.** A small number of organisations (e.g. MAAYGO, IBU) have an explicit aim of improving relationship quality between men, comprising an increased ability to negotiate satisfying relationships and safer sex with other men and a reduction in conflict in relationships. This approach is based on the principle of meeting men where they are at and understanding where they would like to be. It is supported by a wealth of published evidence from sexual health provision among MSM in other countries that demonstrates they are more likely to engage with service providers over a longer period of time if interventions move beyond a disease-prevention approach and work to empower MSM with the knowledge and skills to have more enjoyable sexual relationships.

• **Established and safe referral pathways.** Each CBO that delivers 1-to-1 information and advice interventions has made efforts to establish safe referral pathways when MSM they engage require services that they cannot provide within the organisation. Such services might include: HIV counselling or testing; STI screening and treatment; ART medication; or sites where they can report human rights violations. In each instance, the CBOs have taken steps to ensure that the staff to whom MSM are referred have been sensitised as to their needs and can be trusted to act in the best interests of MSM. Some referral pathways have shown themselves to be hugely productive, and services can now be viewed as symbiotic in nature. For example, CHESA and SANA in Tanzania both have established, good relationships with staff at the PASADA HIV testing and treatment centre, who rely on these CBOs to mobilise MSM to access their clinical services. Similarly, LCVT, who provide HIV and STI testing and treatment in Nairobi and Kisumu have a large number of MSM clients largely as a result of referrals from ISHTAR and MAAYGO.

### Challenges to implementation

• **Age range of clients and service users.** While success has been demonstrated in terms of reaching younger MSM, CBOs (both within and outside of the SHARP programme) have struggled to engage MSM over the age of 30. Concerns about being seen to ‘recruit’ young men to homosexuality means that engaging MSM under the age of 18 is problematic, while it is rare for the CBOs we assessed to engage with men over the age of 30. With few exceptions, men aged over 30 do not attend MSM specific services currently on offer. Until May of 2015, 76% of those being reach by SHARP CBOs were under the age of 30. The staff and volunteers we interviewed felt this reflected a heavy societal and cultural expectation placed on men to marry a woman as they got older. A suggestion was also made that older MSM may have the financial means to attend private health clinics and thus not feel obliged to utilise services offered by the CBOs. While both are plausible explanations, research among MSM in many other countries across the world indicates that men who have had sex with men are unlikely to cease doing so entirely, even when they have entered into relationships with women. Participants of this study reflected that younger men often sell sex to older men.

GALZ has recognised the need to tailor 1-to-1 outreach to different age groups and instead of using their ‘buddies’ (akin to peer educators), they have a different system to engage older men. They recruit
older men to be ‘champions’ who are willing to provide support to other older men. Online outreach is also delivered differently across younger and older age groups. HOYMAS, a CBO based in Nairobi but not a SHARP partner, reports that the age of their service users extends to 45 years old. They offer older, often married, MSM the opportunity to store MSM specific material (such as lubricant or phone numbers of MSM) at their offices, or provide storage space for ART medication for older MSM with diagnosed HIV. This reduces the likelihood that the man’s wife or other family will detect that he is an MSM. By recognising and responding to the specific needs of older men in this way, HOYMAS have been able to retain a larger proportion within their services.

The majority of peer educators currently working with the SHARP CBOs (and all of those we came into contact with at non-SHARP organisations) are aged between 18 and 30. These men are tasked with identifying and recruiting new members or service users, and often use their own social networks (both online and off-line) as a means of achieving this goal. It is possible that this approach, while seemingly successful at engaging MSM aged 18-30, may not allow for the engagement of older men, or even a more diverse group of men in general.

- **Social or financial status of clients and service users.**
  Relating to coverage and equity of intervention access (similarly to the point above), many challenges were described in engaging, and meeting the information needs of, men who occupy different class positions in society. While interviewing academic stakeholders in Kenya and Uganda, concern was raised about the extent to which SHARP partners in those countries meet the needs of more economically disadvantaged MSM, such as those living in slums. Such concerns were also raised by several non-SHARP service organisations in these countries, who often felt that SHARP partners were more accustomed to engaging lower and middle income MSM, but miss the poorest.

However, the SHARP partners describe engaging MSM in disadvantaged financial circumstances via a number of methods. For example, in relation to MSM with diagnosed HIV, IBU and MAAYGO both provide nutritional support for men who are struggling to remain adherent to their ART medication as they cannot afford to eat and SANA tries to encourage and sell products made by HIV positive members. Indeed, SHARP CBOs often articulate the opposite problem – that by virtue of their peer educators usually coming from poorer social circumstances, it is hard for them to engage more wealthy MSM who do not attend the same hotspots, or who ‘look down’ upon them.

Not all CBOs viewed a lack of engagement with wealthier MSM as a problem because they felt that these men had the resources to access private healthcare themselves. However, considering the MSM community as a whole rather than individuals, it is important that all MSM are able to access good sexual healthcare and information, and it is not clear currently whether this is the case, particularly when ‘high status’ men also often described as more ‘hidden’ and harder to reach.

- **Economic security.** For HIV positive MSM, access to food and economic security was a major issue of concern. Many organisations said that while HIV positive MSM were aware of the importance of ART treatment adherence, they lacked sufficient food to take their medication with. Similarly, while many MSM appear knowledgeable about the value of condom use, financial instability meant they were sometimes reliant on sex work and could be paid more if they agree to sex without condoms.

- **Lack of needs assessment information.** Across all SHARP countries, there is extremely limited needs assessment information to help guide intervention development, targeting or tailoring. CBOs generally rely on informal feedback and input from existing clients or service users to decide on the nature and scope of interventions, but this approach fails to capture the needs of MSM not already in receipt of intervention and the lack of population level needs assessment means it is not possible to target those in greatest need. Much of the routine programme monitoring relates to outputs rather than outcomes and, while there are significant resources invested in empowering MSM to utilise condoms during anal intercourse, there is a lack of date to illuminate whether or not this is occurring. A lack of routine needs assessment also means it is difficult to track changes in understanding of HIV/STIs and sexual behaviour among MSM over time.

- **Limited ICT materials.** Development and distribution of ICT materials relevant and accessible for MSM
in Kenya, Tanzania, Uganda and Zimbabwe is significantly hampered by the restrictive cultural and legal environment. The risk of being caught with materials that describe sex between men is so present, and the consequences so great, which means peer educators have to rely on verbal communication of information, with limited opportunities to reinforce learning by visual cues. A lack of ICT materials to distribute also negatively impacts on the CBO’s ability to ‘market’ themselves and their service.

While the internet contains a great deal of information and advice relating to safer sex and HIV for MSM, this is not always accessible to MSM in these countries, is not available in their languages, does not utilise local terminology with which they are familiar, does not reflect their level of education, is not culturally or geographically appropriate (e.g. such as only presenting men of white ethnicity) or does not sign post them to necessary services in their locality. This is a significant barrier to increasing knowledge and understanding relating to safer sex and HIV among MSM.

- Training and resource needs of peer educators. The main mechanism of recruitment into SHARP funded interventions is via peer educators, either meeting men directly in physical hot-spots, or by first engaging them online and then meeting face-to-face. Without widespread access to appropriate ICT materials, they are the primary means by which information and advice are conveyed. However, in discussion with the peer outreach teams and their coordinators, there was evidence that in two of the CBOs peer educators were struggling with the necessary skills or resources to perform this essential duty. While most felt confident in their general description of HIV prevalence, common STIs and condom use, others were not confident in their understanding of the biology of HIV transmission or had struggled to understand how ART operates. In one case there was evidence of misconceptions relating to how HIV is transmitted and confusion around the role of semen or the likelihood of infection via anal intercourse. Peer educators were generally united in their request for further training.

As a related challenge, peer educators typically adopt a role as non-paid member of the CBOs but who typically receive expenses (such as transport or phone credit) for their duties. While most recognised the financial limitations of their CBOs and understood it was unlikely they could be remunerated for their work, requests were made for non-financial incentives, such as bags or clothes that might aid them in their duties and demonstrate investment in them as individuals.

As is the case in voluntary positions in every country and in relation to most health or social care issues, individuals can only volunteer their services for a finite

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**CASE STUDY 3 GALZ: 1 to 1 information and advice with older men**

In Zimbabwe, GALZ has recognised that the set of issues that older men are dealing with (>30 years old) often differs from that of younger men. They report that older MSM with whom they are in contact are sometimes coping with loneliness, aging and HIV, coming out to children, and hiding their sexuality and relationships from family and divorce. They also tend to already have heard of GALZ, have higher levels of income and/or education than the younger men. Despite this, older men might have higher risks due to hiding their relationships and the resulting stress. These dynamics can also lead to rifts between older and younger men, and tensions arise around intergenerational relationships with both parties feeling taken advantage of. GALZ has previously mediated a discussion on this topic.

All of these differing needs and tensions, as well as social status conferred with age, have meant that GALZ has found it beneficial to tailor their outreach and support services by age group. GALZ’s peer educators, tend to be young and thus are less suitable as primary entry and contact points for older men. Instead, GALZ has developed a separate network of ‘Community Leaders’ in towns across the country. These are older members who have volunteered to provide support and with whom GALZ can facilitate contact. When GALZ newly makes contact with an older MSM, they approach a Community Leader to confirm that both parties are happy to exchange contact details. The Community Leaders can then provide social support, advice, and serve as a conduit to GALZ’s services and referrals if these are requested.
period before other financial or practical concerns become more salient.

- **Scale of information, advice and other services.** While technically a challenge that spans multiple interventions and settings, many CBOs voiced concern or frustration regarding the expectations of the target MSM population as to the services they are able to provide. As organisations led by MSM with the target of supporting other MSM, they are faced by increasingly complex demands on their time and resources by communities who misunderstand the nature of their funding and assume they can provide support in relation to a wide range of social, practical, health and financial issues. When the CBOs, usually resourced for interventions specific to HIV and human rights, are unable to meet these expectations, they can receive harsh criticism from the community. All parties recognise the need to better articulate what information, advice or services they can and cannot provide, while still ensuring the safety of their members and working towards meta-level aims of improved health and well-being for MSM in their country.

- **Potential duplication of outreach.** While less the case in Dar es Salaam or in Zimbabwe, in Nairobi and Kampala there are a larger number of CBOs that claim to provide 1-to-1 information and advice to MSM during outreach. Several of these are demonstrably MSM-led (such as ‘Youth on Rock Foundation’ and ‘Spectrum Initiatives’ in Kampala, or HOYMAS in Nairobi), while the leadership of several others is harder to determine. All claim to serve the needs of all MSM in their locality and describe outreach interventions that have overlapping aims. While not necessarily problematic that MSM might engage with more than one organisation (who may be able to offer slightly differing advice or linkage to services), there may be value in greater coordination or partnership working to avoid duplication wherever possible.

- **Recording of online 1-to-1 information and advice.** While there are clear and well-established processes for recording and registering MSM provided with information and advice in face-to-face settings, many peer educators and CBO staff felt confused if and how to record interventions with men ‘reached’ in online environments. As previously stated, many peer educators made their first contact with potential new clients via social media, although ISHTAR peer educators estimate that only 3 in every 5 online contacts results in a face-to-face interaction and registration. Valuable information and advice may have been imparted, but the means of recording this and evaluating its impact as programme activity, or ensuring that duplication of existing clients does not occur, is a continuing challenge.

### 4.3.2 Group information and advice

Interventions falling into this category are those that operate on a group basis, providing MSM participants with information or advice about safer sex, HIV, healthy relationships or issues relating to human rights and personal security. Often such group sessions take place within the CBO offices but may occasionally be convened in other rented sites or outdoors. Since the SHARP programme began, 1746 MSM have been part of group information and advice interventions, the typical aims and objectives of which are presented in Table 4.2.
### Aim Objectives (such as the following)

**To increase men's knowledge about HIV, its exposure and prevention**
- An increased proportion of men are aware of high HIV prevalence among MSM
- An increased proportion of men understand how HIV is transmitted during sex
- An increased proportion of men understand the consequence of HIV infection for their health
- A increased proportion of men understand how effective condom use can prevent HIV transmission

**To increase men's knowledge about STIs, their symptoms and prevention**
- An increased proportion of men understand the prevalence of STIs among MSM in their area
- An increased proportion of men can recognise the symptoms of certain STIs common among MSM
- An increased proportion of men understand how STIs can be avoided, by the effective use of condoms

**To improve the psychosocial well-being of MSM**
- To enable MSM to feel more comfortable with their same-sex attraction (to address issues of internalised homophobia)
- To empower men to ‘come out’ to family and friends, should they wish to do so

**To increase men's knowledge of how to live well with HIV and services that support this**
- An increased proportion of men with diagnosed HIV understand the importance of HIV treatment adherence
- An increased proportion of men with diagnosed HIV understand the importance of careful nutrition
- An increased proportion of men know who they can talk to in a neutral and non-judgmental manners about their feelings and experiences

**To increase men's knowledge of how to improve psychosocial well-being and services that support this**
- An increased proportion of men know who they can talk to in a neutral and non-judgmental manners about their feelings and experiences
- An increased proportion of men understand how they address feelings of internalised homonegativity

**To increase men's knowledge and awareness of their human and legal rights**
- An increased proportion of men are aware of where they can access MSM friendly health services
- An increased proportion of men are aware of the legal right to health for MSM (in line with all citizens)
- An increased proportion of men are aware of their legal rights and how to report homophobic attacks

**To facilitate an environment of group and peer support and interaction**
- To increase opportunities to share experiences of living as an MSM and/or a man who has diagnosed HIV
- To increase opportunities to share solutions to common problems
- To increase opportunities to share information

---

**TABLE 4.2 Aims of group information and advice interventions**
CASE STUDY 4  ISHTAR Post-test club

ISHTAR in Nairobi have developed what they call the ‘Post-test club’ – a group information and advice intervention that brings together MSM who have received either a positive or a negative HIV test result once a month for a 12 month programme of group meetings where issues relating to safer sex, HIV prognosis and treatments are explored. One of the overarching aims of this intervention is to tackle HIV related stigma within the local MSM community. By placing both HIV positive and negative MSM alongside one another – but not disclosing who is who – the hope is that they each gain a valuable perspective on the issues faced by people with HIV and how safer sex can be negotiated in sero-discordant partnerships. Tackling HIV stigma on a broader level can help to improve the psychological well-being of MSM with diagnosed HIV and may facilitate status disclosure.

Strengths

- **Inclusivity and specificity.** Those CBOs that deliver group information and advice interventions are clear to emphasise that they are inclusive of individuals regardless of their age, social or financial status. Where appropriate, however, they draw on their strengths with particular sub-populations, such as MSM aged 18-21 or MSM with diagnosed HIV and provide a safe and focussed in space in which they can explore common issues and concerns.

- **Attending to political and cultural circumstances.** Groups are often constituted to discuss issues relating to human rights and security for MSM. They are used to disseminate information about rights to health and justice and inform men how and where to access support or to report human rights violations. The effectiveness of HIV prevention and care interventions for MSM will be compromised as long as they are unable or unconfident to access services for fear of discrimination or violations of their human rights.

Capacity for impact

- **Tackling HIV related stigma.** While stigma related work happens as part of 1-to-1 information and advice interventions (to varying extents by different CBOs, based on the individual need of clients), this issue is most commonly addressed within group interventions.

- **Consideration of psychosocial well-being.** MSM often experience rejection from families or communities when they disclose their same-sex attraction and are thus left without essential social support structures. The advantage of group sessions, over and above 1-to-1 information and advice interventions, is the social interaction and cohesion that they can facilitate. Sharing of anxieties and concerns with others in similar circumstances provides a psychotherapeutic benefit, as well as an educational one that encourages safer sex.

- **Engaging environments.** Recognising the need to work with young MSM, especially those with diagnosed HIV, in relation to HIV stigma, IBU in Kampala have established a space called ‘Youth Dialogues’ where they bring together young people for an away-day outside of the city. The most recent event was held on the shore of Lake Victoria where food was provided and games organised throughout the day. Time was also set aside to have a group discussion with the young people about issues relating to HIV and stigma, as well as safer sex. Such environments are engaging for the target population and help to facilitate longer term engagement with the CBO for access to valued activities.

Challenges to implementation

- **Vocational training.** Linking with pressing concerns about the economic security of MSM, a desire was expressed by several CBOs to provide more opportunities for vocational skills training, which could enable economic empowerment. This was considered especially pressing for MSM who sell sex and for whom vocational training might have the greatest impact in future avoidance of risky sex. While not a primary goal of SHARP, non-provision of desired interventions can jeopardise relations with the target population and requires sensitive communication.

- **Retention.** As is the case in many group based interventions, there is a common concern relating to
retaining MSM for the full course of group sessions. Issues of holistic sexual health provision and availability of desirable ancillary services are once again salient.

- **Fear of disclosure as a member of a group.** While CBOs recognise the need to target group discussions to different parts of the MSM community, and have found this to work well in some cases (such as with CHESA, MAAYGO and iBU), the intense fear of disclosure amongst HIV positive men can prevent them from attending sessions addressed at them in particular. In the case of both GALZ and SANA, the HIV positive support group is in fact a separate but affiliated and supported organisation to the CBOs themselves. The downside to this separation may be that stigma within the MSM community related to HIV is not addressed.

### 4.3.3 1-to-1 clinical interventions

These interventions also constitute a large component of work for many SHARP partners, and are the sole intervention delivered by many of their clinical partners. Designed to diagnose and treat HIV and sexually transmitted infections among MSM, 1-to-1 clinical interventions may be carried out within the offices of the organisation (e.g. a drop-in service) or may be delivered as part of outreach activities, or at larger events or parties. As of May 2015, a total of 6204 HIV tests have been recorded as part of routine SHARP programme monitoring. However, this figure likely underestimates the number of tests attributable to programme activities, as some tests that occur as a consequence of referrals to other clinics may not be captured. Within the same time period, a total of 4286 MSM were seen by SHARP CBOs for screening of other STIs. Aims and objectives of 1 to 1 clinical interventions are presented in Table 4.3.

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives (such as the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase access to HIV testing and treatment</td>
<td>An increased proportion of MSM are able to take a HIV test in a safe environment</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of MSM test for HIV on a regular basis</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of MSM who test positive for HIV have access to effective medication</td>
</tr>
<tr>
<td>To increase access to STI testing and treatment</td>
<td>An increased proportion of MSM are able to be screened for STIs in a safe environment</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of MSM screen for STIs on a regular basis</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of MSM with STIs are diagnosed early and receive effective treatment</td>
</tr>
<tr>
<td>To increase the settings in which clinical services are provided</td>
<td>An increased number of safe, skilled spaces are created when MSM can receive HIV or STI testing and treatment</td>
</tr>
<tr>
<td>To increase referral to psychosocial, sexual and other support services to MSM attending clinical services</td>
<td>An increased proportion of men know where they can access further medical help or support following a diagnosis</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of men take up referrals to other social and clinical services</td>
</tr>
</tbody>
</table>
Strengths

• **Partnership working.** Most of the CBOs (including MAAYGO, SANA, CHESA and IBU) have developed efficient partnership models with local state-run clinics or larger sexual health NGOs that have been sensitised to the specific needs of MSM (see Chapter 5). As previously described, peer educators will often make referrals to such clinics during the course of outreach work and those CBOs with their own clinics will make referrals for complex cases or when treatment is required. This approach helps to ensure longer term sustainability of services for MSM and can extend their geographic reach beyond those who can attend their own clinic locations. Several SHARP CBOs already have memoranda of understandings established with other organisations, especially those providing clinical services. These establish the circumstances in which referrals are made and emphasise the minimum service guarantee for MSM, including assurances of safe and non-judgemental treatment.

• **Trust in clinical services.** Attending clinical services for diagnosis and treatment for sexual infections requires an extremely high level of trust, especially when such infections might indicate same-sex experience (such as anal warts). The fact that CBOs are able to engage and refer a high number of MSM for HIV counselling and testing indicates a confidence in clinic and CBO staff.

• **Open to the local community at large:** CBOs providing HIV testing in at their offices (e.g. ISHTAR, SANA) have stated that they also welcome members of the local community to test also, which they report as beneficial to their community relations and allow MSM to attend for testing without having to identify as attending a specific MSM testing centre. There is likely also a need though to ensure that MSM feel safe within the CBO space.

Capacity for impact

• **Support for ART adherence.** Many CBOs (such as IBU, MAAYGO, SANA, CHESA, GALZ) provide ART adherence interventions for MSM with diagnosed HIV. While often a relatively informal situation, whereby the counsellor regularly checks in with members, these interventions are holistic in nature and take into account their social, familial and financial circumstances as determinants of their adherence. In Tanzania and in Zimbabwe, there are also positive support groups, which while strictly autonomous from the CBOs, are referral points for men who test positive.

• **HIV counselling and testing.** As a principle outcome of SHARP testing activity, more MSM are empowered with knowledge of their HIV status and can take steps to ensure their well-being. Programme monitoring indicates that up until August 2015, 6204 MSM had received an HIV test, with 5609 of these being new CBO clients, and the remainder repeat testers.

• As a secondary outcome, more MSM within the region with HIV have had their infection diagnosed, facilitating access to ART medication that can reduce their viral load. This reduces their own risk of HIV progression and also the likelihood of onward transmission to new sexual partners. SANA, CHESA and GALZ distribute cards for repeat HIV test appointments among MSM testing negative and they report that at least half of these men with appointment cards come again.

• **Plurality of HIV testing options.** SHARP CBOs have established a number of mechanisms for HIV testing, determined by their local circumstances and available resources. For example, MSM in Nairobi can test at the ISHTAR drop-in-centre or at a local hospital whose staff have been sensitised to the sexual health needs of MSM. Men in Tanzania can test at SANA’s office based clinic (or CHESA’s, once it is re-established), at the known to be MSM friendly PASADA clinic, or at the mobile caravan taken with TAPP to different neighbourhoods in the city. No one testing option will be acceptable or preferred by all MSM and enabling choice of testing venue is fundamental to driving down undiagnosed HIV infection. However, care must be taken to carefully calibrate services to meet the needs and preferences of the local MSM population, such as how far they have to travel, who performs the test, where and how they can receive care and treatment (if required) and what ancillary services (such as condoms & lubricant provision) are provided. Understanding further the basis for these preferences, as well as the long-term outcomes for HIV positive men who initially test at one of the other locations, could be beneficial for continuous improvement of services.
**Challenges to implementation**

- **Limitations of STI screening.** Currently the CBOs with clinics at their own offices (ISHTAR and IBU and SANA) are only able to provide syndromic screening of STIs (with the exception of occasional ad hoc access to testing kits). There remains, therefore the possibility of undiagnosed, asymptomatic STIs, which continue to be transmitted within the population.

- **Limitations of STI treatment.** The SHARP programme currently provides for treatment of STIs – either at the CBO office-based clinic, or at the state hospital if sent by referral. However, there are limits to the range of treatments available and several clinical staff voiced frustration at the lack of treatments for anal warts, which are considered endemic among MSM in the region. While provision of treatment is understandably restricted by programme and other CBO resources, problems accessing effective treatments can both perpetuate the spread of STIs in the community and may lead some MSM to disengage with services.

- **Retention in clinical services.** While currently difficult to determine conclusively due to monitoring structures, concern was raised by many staff and peer educators regarding retaining MSM in clinical services over longer periods of time. There has been success in encouraging MSM to test for HIV, but it was generally considered uncommon for MSM to return to the same testing centre for regular tests. Currently most SHARP CBOs advocate 3-monthly testing for MSM, but there was doubt over whether this target was being met.

- **Access to other medical treatment.** Adopting a principle of holistic health and well-being for MSM, many CBOs make referrals to a range of medical services, beyond sexual health (e.g. TB or mental health services). While the CBO covers medical expenses (or at least transport costs) wherever possible, in many instances this is beyond their resources and the MSM are unable to cover the costs of diagnosis and/or treatment. Such medical resourcing is clearly beyond the remit of this programme, with its focus on HIV and sexual health, but does have implications for how MSM engage with the CBOs over the longer term. It may impact on their perception of such CBOs ability to effect meaningful change to their health and well-being.

- **Requirements for official registration:** In every country, permission must be gained from the authorities to provide HIV testing and counselling and sexual healthcare services. Staff delivering such interventions need to be trained and registered with relevant health authorities. It has been difficult for CBOs to provide the necessary infrastructure and training to meet local approval, causing delays.
Interventions within this category are typically unidirectional and non-interactive in nature. While 1-to-1 individual or group information and advice involves an exchange between the peer educator and the target MSM (either in an online or physical outreach setting), broadcast media interventions involve dissemination of information without 2-way interaction. Examples include interventions that are facilitated by radio, Facebook groups or WhatsApp groups. There are exceptions, particularly in the case of social media whereby information can be broadcasted to MSM in the online community and discussion or debates arises, but this may not necessarily be the principle aim of broadcasting the information. Aims and objectives of broadcast media interventions are presented in Table 4.4.

**TABLE 4.4 Aims of broadcast and social media interventions**

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives (such as the following)</th>
</tr>
</thead>
</table>
| To increase awareness and understanding of the prevalence of HIV and STIs, and how they can be prevented | An increased proportion of men understand the HIV prevalence of HIV among MSM  
An increased proportion of men understand how HIV is transmitted  
An increased proportion of MSM understand and recognise common STIs  
An increased proportion of men understand how to use condoms effectively to prevent HIV or STI transmission |
| To improve awareness and uptake of health and CBO services by MSM | An increased proportion of MSM are aware of the services that CBOs can offer and how they may be valuable in maintaining health and well-being,  
An increased proportion of MSM know where they can safely access sexual health services for HIV or STI testing and treatment (e.g. those not offered by CBOs) |

**CASE STUDY 5 IBU Mobile Clinic**

IBU, based in Kampala, have expanded their outreach from just being centred on the capital to throughout the West, South and East of Uganda (with plans to go to the North in 2015). Through these outreaches, services are now available to MSM in Jinja, Mukono, Mbarara, Ntungamo, Masaka, Tororo, Fortportal, Kasese, Wakiso, Hoima, Mbale and Entebbe as well as Kampala.

This tremendous expansion of geographical reach happened in the immediate aftermath of the passing of the Anti-Homosexuality Act. This intervention is made possible by a strong partnership with MARPI, a KP clinic and NGO working under the auspices of the Ugandan Ministry of Health. An agreement was reached between IBU and MARPI to integrate the IBU services and staff with those provided by MARPI. IBU covers the cost of all staff, travel, medicines and commodities. A comprehensive outreach team of clinicians, laboratory workers, counsellors, M&E staff, driver and outreach co-ordinator travel to the outreach location to connect with local MSM CBOs and IBU affiliated volunteers.

IBU uses its network of MSM CBOs and locally based peer educators to mobilise the local MSM population (see section 4.3.1). By doing the outreach with MARPI and by also targeting general population and sex workers at the same time IBU are able to effectively reach and connect MSM with services operate ‘invisibly and in plain sight’.

IBU and MARPI staff provide HIV counselling, testing and diagnosis on-site, as well as syndromic STI screening and distribution of prevention commodities, information and education on HIV and SRHR. Referrals are made to local state-run hospitals for treatment when necessary. To date, IBU have not been able to keep pace with demand for this service, perhaps due to limited availability of MSM friendly sexual health clinics outside of Kampala.
CASE STUDY 6  GALZ Facebook media work

GALZ uses Facebook to achieve a variety of specific objectives and to reach different sections of the Zimbabwean MSM community. Reported objectives include sharing experiences, creating a forum for mutual support, providing health information, sharing information about the LGBTI community elsewhere in the world, sharing research findings and discussing fashion. In order to do this, they have developed several different Facebook groups, in some cases seeding them from the beginning, and in other cases participating in existing groups. The various GALZ run pages vary from 208 to 1,869 members and one of the closed groups they contribute to has 8,422 members.

Health information is mixed into a wider range of topics felt to be appealing to the target population, and a range of professionals have been invited to participate, including fashion designers, gardeners, artists and chefs. There are also a range of other Facebook groups that GALZ staff monitor and post targeted information to, including those aimed more at sexual hook-ups, and those that provide sexual health information. These pages are all kept separate from the GALZ organisational Facebook pages. GALZ reports that it now makes initial contact with many of its new members via social media.

While their strategy appears to have been successful, it has required a large investment of time. Initially, the seeded groups took a lot of effort on the part of GALZ staff, who tended to be the only posters. As the groups became more popular and discussion over comments grew, others began to post. While this somewhat reduced the demands on staff time, the overall volume of personal messages is high. This is the means by which many men have been making first contact and they need to be dealt with on a regular basis. Additionally, there are tensions around privacy and security. It is likely that some of GALZ’s work on Facebook has benefitted from the profile and status that named staff involved in the groups have among the MSM community in Zimbabwe. Using personal profiles might not, however, be an acceptable strategy for all staff members or volunteers at SHARP. Nonetheless, the targeting to groups, seeding of discussion, mix of different types of information and separation from organisational pages could be useful strategies for other CBOs.
Identifying and maintaining supportive media. Developing and maintaining links with media (especially radio) who are supportive of MSM and the efforts of the MSM CBOs is a significant challenge. Those CBOs that have delivered radio interventions – MAAYGO in Kisumu and SMUG in Kampala – had to invest considerable time and resources building trusting relationships with radio station staff.

Challenges to implementation

Establishing reach. Broadcast media interventions are notoriously difficult to evaluate; it is hard to determine the proportion of your target population who heard or saw the broadcast and what impact it had. This challenge is similarly reflected for SHARP CBOs who are delivering this form of intervention.

Language accessibility. With such a wide range of languages spoken across the 4 SHARP countries, difficult decisions have to be made about which language broadcast should be made in. While English, Kiswahili, Luo and Shona are widely spoken, CBOs are often concerned they are not reaching some sections of their populations if broadcast only in these languages – particularly when also considering the issues of engaging poorer men from slum areas (outlined in section 4.3.1).

Cost. Broadcast media interventions facilitated by radio are among the most costly interventions, which is particularly important to consider given the difficulties in estimating how many MSM may have heard the broadcast.

Time. In the case of social media, most CBOs stated that involvement can be very time-consuming. Maintaining a number of groups on Facebook and equivalent sites on other social media platforms can be extremely time consuming. There is initially a lot of effort required to ‘seed’ discussion. Once participation from others increases, there is still a lot of heavy involvement with reading, posting and responding to comments.

Privacy and security. On the one hand, social media spaces have the potential to provide safe spaces for MSM who do not feel comfortable engaging with CBOs in person. On the other hand, MSM are often understandably reluctant to use named profiles and this means that it can be difficult to maintain engagement with individuals over time. In Tanzania, there were reports of MSM being baited by malicious strangers online. CHESA is still struggling to understand the best social media approach for them as an organisation in the wake of their previous de-registration and the fear of being perceived by authorities as ‘promoting homosexuality’. The use of private groups and other approaches could help.

CASE STUDY 7  Radio broadcasts by MAAYGO

In 2014, MAAYGO in Kisumu held six, 45-minute talk shows on a Western Kenya radio station. They opted for a local, Luo language service so that the message of their broadcast could be accessible to MSM who were not fluent in English or Kiswahili. This radio station has an estimated 4 million listeners. For each broadcast they discussed different issues relating to HIV prevention, sexual health or promotion of services available to MSM.

The shows also provided an opportunity for listeners to call in with questions and sought to dispel myths or misunderstandings. Where appropriate, callers were also linked to relevant health services. This intervention was only made possible by careful negotiation with the radio station, who were initially hesitant to allow discussion of homosexuality on the air. MAAYGO would, in future, like to raise issues relating to human rights for MSM and other LGBT people but, for the moment, they do not wish to endanger relations with the radio station managers who fear a public backlash were they to do so.

The shows contributed to MAAYGO’s objective of informing and educating listeners (including MSM) on health and HIV. At the same they also helped to tackle myths about homosexuality and to address stigma, discrimination and violence against MSM from the local communities, which are explored in Chapter 5 (community level interventions).
4.3.5 Distribution of condoms and lubricant

All CBO’s engage in the distribution of condoms and lubricant as part of their activities. Since the initiation of the programme, a total of 58,949 condoms have to date been distributed by SHARP implementing partners. These are made available with peer educators when visiting clients outside of the office, at the offices and during other events, such as parties. In some cases, such as in Dar es Salaam, condoms and lubricant are packaged as ‘health kits’ and delivered together alongside other materials including Dettol and mouthwash and leaflets describing their use. CBO’s also make efforts to supply condoms and lubricants to their contacts around the country, though this generally involves someone having to personally transport them.

**TABLE 4.5** Aims and objectives of condom and lubricant distribution

<table>
<thead>
<tr>
<th>Aims</th>
<th>Objectives (such as the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase the availability of condoms and lubricant for use by MSM</td>
<td>An increased proportion of men are provided free condoms and lubricant in information and advice settings</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of men are provided free condoms and lubricant during clinical interventions</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of men are provided free condoms and lubricant during community and peer based interventions</td>
</tr>
</tbody>
</table>

**Strengths**

- **Accompanied by education.** The context in which most condoms and lubricant are distributed means that MSM also received education on their use, either verbally from peer educators or via leaflets. Peer educators are thus able to explain effective usage and respond to queries.

- **Adapted to the local political and security context.** Because distribution of condoms and lubricant might put peer educators at risk of being accused of ‘promotion of homosexuality’, and because receiving materials might also put clients at risk of exposure, CBOs have developed careful procedures around their distribution.

- **Popularity and accessibility.** All CBOs cited high demand for lubricant and many (especially those in Uganda and Western Kenya) even described its function as an incentive for clinic attendance or attendance at other events.

**Capacity for impact**

- **Delivery of materials in a format and at locations useful to many MSM likely reduce infections.** Additionally, because of the very low availability of water-based lubricant in the absence of the CBO’s distribution, it is likely that this intervention does have impact in reducing the likelihood of HIV and STI transmission, provided that men do understand its usage as a prevention material alongside condoms.

and the use of a tailored strategy using Facebook in particular has been effective in generating discussion and linking to new clients in Zimbabwe.
Challenges to implementation

- **Supplies of water-based lubricants.** All CBOs described challenges in obtaining a sufficient and reliable supply of water-based lubricant to distribute to clients. There is very low availability of water-based lubricants within SHARP countries and when available, it tends to be very expensive and available only in large containers unsuited to the needs of many men. However, because of its association with anal sex, governments create restrictions to importing lubricant into SHARP countries. Because of this, SHARP CBOs have not been able to distribute as much lubricant as they would like, and this also creates disappointment amongst the MSM community with the CBO, jeopardising longer-term engagement.

- **Integrating condom distribution with health education.** IBU, GALZ and MAAYGO expressed a need for research into how men are actually using the condoms and lubricant they distribute. There is concern that men might be using only lubricant or that they believe it to be effective in preventing HIV and STIs on its own. Many CBOs are considering ways to improve the delivery of condoms and lubricant, such as integrating condoms and lubricant into one linked packet to reinforce the idea of using them together.

- **Access to non-latex condoms.** CBO's also lack access to non-latex condoms for clients who are allergic to latex. There was also misunderstanding or lack of certainty expressed by a few peer educators who were not familiar with latex allergies and the problems this can present for effective condom usage.

- **Security situation.** Carrying and distributing packets of condoms and lubricant, particularly alongside educational materials aimed at MSM, can put peer educators and MSM receiving the materials at risk of harassment, assault and potentially prosecution under laws in each country relating to the ‘promotion’ of homosexuality. CBOs have adopted strategies to reduce these risks, and are very careful about how and where they distribute condoms and lubricant in public settings, but the challenge remains.
This chapter explores interventions that seek to improve the social environment in which MSM live. Such interventions are typically focussed on addressing meta-level issues, including stigmatisation or marginalisation (of both MSM and people living with HIV), which can negatively impact on the health and well-being of MSM, and make it harder for them to access services that meet their needs.

‘Community’ can be seen as operating at a number of levels: a community of people in a specific geographical area; a community of LGBT or MSM people in a given area; a community of HIV positive MSM etc. As such, the interventions described in this section vary in terms of their scope and target audience. Interventions to improve the social environment for MSM can also involve lobbying of policy or decision makers, who have a role in health, security or human rights policy. This is what we mean by a ‘structural level’ intervention.

In this chapter we begin by describing the ways in which MSM CBOs and linking organisations engage with community or structural level stakeholders, before describing the aims and appraisal of interventions according to a defined typology. When considering the appraisal of these interventions, it is worth bearing in mind that nearly six months was spent by the in-country teams (both CBOs and Los) developing work plans that define and address the intervention development need in their own context, responsive to the prevailing political and cultural circumstances.
5.1 ENGAGING THE COMMUNITY AND POLICY/DECISION MAKERS

MSM CBOs and linking organisations engage with members of different communities and policy/decision makers in a number of ways:

- Social/cultural events that engage the wider community with issues relating to MSM or other sexual minorities (such as PRIDE, IDAHO or World AIDS day events);
- Direct physical approach to community leaders, tribal elders or chiefs, and religious leaders;
- Utilising broadcast media, such as the radio (sometimes following mapping of MSM friendly media outlets);
- Engaging in policy development meetings with local or national HIV policy bodies.

The initial approach to each individual or community often only arises once a preliminary assessment of their role, remit and perspective of MSM has been assessed. The safety of staff making an approach is clearly paramount at these times.

5.2 OVERVIEW OF COMMUNITY/STRUCTURAL LEVEL INTERVENTIONS

Community and structural level interventions in SHARP can be described as falling into two types, according to their overarching aim. Among the first are those that broadly seek to foster links among MSM and enhance the connectivity of the MSM community (e.g. enhancing how MSM feel about themselves). The second is those that seek to influence how the wider social and geographic community perceive MSM and take account of their needs (e.g. how other people feel about MSM). The specific nature of the intervention is informed by the local environment, including existing laws or those that are currently being debated (such as the Anti-Homosexuality Act in Uganda in 2013). Interventions can be further sub-divided into the following types:

1. **Enhancing the connectedness and resilience of the MSM community**: establishing and maintaining links between MSM (and MSM sub-groups) in geographical regions for the purposes of community cohesion, social capital and collective resilience to stigma and discrimination.
2. **Encouraging supportive communities**: In addition to interventions that operate at the community leader level, some interventions target the general public in communities to improve their perspective on MSM and their human rights (such as those described in 5.2.2).
3. **Sensitisation of religious, traditional or other community leaders**: typically involves training to educate and inform about public health, human rights and the place of MSM in communities.
4. **Policy advocacy & lobbying**: Ongoing work with policy and decision makers in local and national governments to enhance the focus on HIV among MSM, as well as advancing human rights of the population.
5.2.1 Enhancing the connectedness and resilience of the MSM community

Interventions falling within this category typically aim to build or develop communities of MSM for enhanced personal well-being, relationships, and to facilitate collective resilience from the societal stigma that many men face. The methods utilised by SHARP partners can vary, but typically involve MSM (or wider LGBT) community events that enable men to meet and interact. Less commonly, such interventions may incorporate social media, such as establishing online groups for the express purpose of connecting MSM (rather than for HIV education or advice).

Given the focus on resilience, also considered within this section are interventions that seek to improve the security situation for MSM and their capacity to respond to human rights violations. Although these typically involve individual level responses (explored in section 4.3.1), the overarching aim is to improve the social environment for MSM, and hence they are considered here as a community level intervention.

Aims and objectives of interventions that seek to enhance the connectedness and resilience of the MSM community are presented in Table 5.1.

### Table 5.1  Aims and objectives of MSM connectedness and resilience interventions

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase opportunities for MSM to meet other men for friendships or relationships</td>
<td>MSM have increased opportunities to meet other MSM for friendships or relationships</td>
</tr>
<tr>
<td></td>
<td>MSM have increased opportunities to socialize with other MSM without fear of discrimination or abuse</td>
</tr>
<tr>
<td>To increase opportunities for MSM to socialise with other men without fear of abuse or discrimination</td>
<td>An increased proportion of MSM have the opportunity to meet one another in safe environments</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of MSM are able to access support and advice about living well from other MSM</td>
</tr>
<tr>
<td>To improve mechanisms for the reporting and documentation of human rights violations</td>
<td>An increased proportion of men are able to report their experience of human rights violation in a timely manner</td>
</tr>
<tr>
<td></td>
<td>An increased proportion of men who are the victims of human rights violations are able to access supportive health and social care interventions</td>
</tr>
</tbody>
</table>

**Strengths**

- **Understanding of motivation.** Those organisations who have devised parties and other social events have recognised that a core motivation of many MSM is to meet and interact with other MSM. As a socially isolated, often small, population of men, opportunities to meet in safe social spaces can be very limited. While HIV and health may be individual concerns, these are often outweighed by a more fundamental desire for social interaction with other MSM. Interventions that recognise this can fulfil an important social function, as well as providing the environment for delivering other one-to-one information and clinical interventions (see sections 4.3.1 and 4.3.3).

- **Recognising the value of social capital.** Research in a number of health domains has indicated the value of social capital (e.g. the collective value of networks and the notion of people within a community doing things for one another) in meeting the aims of interventions. While not necessarily expressed in these terms, many SHARP interventions appear to have at their core a belief in the value of such MSM networks in helping to effect meaningful change in the sexual health of their community.

- **Engaging young people.** The SHARP programme has demonstrated considerable success in reaching young MSM from across all 4 countries. CBOs have developed a number of innovative engagement models, such as IBU who host “Youth Dialogues” in which they aim to facilitate a fun and engaging setting.
for young MSM and transgender people to meet, interact, and learn about HIV and safer sex. Research in many other country contexts has highlighted the isolation often experienced by young MSM as they seek to understand and accept their sexual identity and, as such, any intervention that seeks to enhance social connectivity among this age group and population is welcome.

### Challenges to implementation

- **Establishing effectiveness and impact.** As is the case with many interventions operating at a community level, which involve a very large constituency of people, it is hard to demonstrate impact and how community events may contribute to the goal of reducing HIV incidence among MSM. This, in turn, makes it harder to secure funds for these purposes.

- **Establishing the identity of the organisation when providing both social and health promotion activities.** While there are undoubtedly benefits to providing both types of activities for members for engaging men, there are difficulties managing expectation among members. ISHTAR and GLAZ both reported that members sometimes expressed a preference for more social events at the expense of health promotion activities, indicating that the balance of activities can be difficult to achieve.

- **Engaging the diversity of MSM.** As expressed in the previous chapter, it has proven very difficult for most SHARP partner organisations (as well as other MSM organisations in each country) to engage MSM older than 30, and men who live in poorer circumstances (such as those in slum areas) in one-to-one or group interventions. This challenge extends to community level interventions in a similar manner, but therefore limits the scope of social capital and resilience.

### Capacity for impact

- **Understanding and responding to need.** The human rights monitoring and response systems in place or in development are a direct result of recognised need to capture such information for lobbying purposes. They also enable meaningful and well-resourced help for the individual who has experienced a violation, which itself increases reporting rates.

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**CASE STUDY 8  **GALZ & SANA: Combined internal and external community building events**

All the SHARP CBOs provide social events for members to encourage and celebrate their community while sometimes strategically linking these to international awareness events. For example, GALZ supports a committee organising yearly Pride week activities. These activities perform both internal community strengthening and external visibility and advocacy roles. In 2013’s, the GALZ Miss Jacaranda drag pageant was widely reported in the international press. At the time of appraisal visit to Tanzania, SANA was planning community-building activity days in which staff and members would go into their local neighbourhood and conduct community charitable activities. The internal events are aimed at enhancing the social bonds among MSM, their families and friends. The external events and activities are aimed at increasing the CBOs’ visibility and demonstrating their positive commitment & interest in and for the local community.
In 2014, the International HIV/AIDS Alliance began the rollout of Rights-Evidence-ACTion (REAct), a community-based system for monitoring and responding to human rights violations for MSM. REAct documents human rights-related barriers in accessing HIV and health services in order to provide adequate individual responses and to inform quality human rights-based HIV programming, policy and advocacy at national, regional and global levels.

Uganda is one of the first countries where REAct is being piloted and is coordinated by SMUG and implemented under SHARP in partnership with IBU and Spectrum Initiatives. The start-up process involved consulting with SMUG member organisations and facilitating a workshop with SMUG, IBU and Spectrum to understand the system. The REAct partners then agreed the composition of the REAct committee (to oversee plans and programming) and an Emergency committee (to make decisions in relation to exceptional emergency responses above an agreed ceiling of $50). Roles and responsibilities, the small grant scheme (which provides for immediate emergency responses of up to $50 per individual case) and data collection, management, sharing and analysis were also agreed.

REAct allows SMUG, IBU and Spectrum to document human rights violations against MSM (and others at higher risk of HIV) in a systematic fashion. It comprises a paper-based questionnaire that is delivered to the individual in person or over the phone, which is then transferred to the computer and combined with photos and other evidence. Spectrum Initiatives provide a toll free number to ensure access for MSM who live further from Kampala, or who do not wish to meet in person. The electronic data is stored securely on servers outside of Uganda. A crucial, additional component to REAct is the provision of resources to respond to human rights violations as and when they arrive. The participating CBOs can organise (and pay for) medical treatment if required, refer to MSM friendly police or lawyers, facilitate emergency shelter or housing, or therapeutic support.

The initial phase required the understanding and integration of slightly different human rights monitoring systems at each of the three CBOs, as well as harmonising financial and accounting systems for the response mechanism. While the system has not yet been subject to a detailed evaluation (planned for 2015), feedback from recipient MSM is extremely positive. The addition of the response mechanism means there is greater perceived value in reporting (where before many felt nothing positive would arise from doing so). Like other interventions among MSM in this region, at the moment REAct disproportionately attracts men aged 18-30. This may reflect the greater visibility of this age range (leaving them more susceptible to human rights violations), and their greater willingness to step forward to report them when they occur. Efforts to promote the system to a wider age range, as well as Transgender and HIV positive MSM are ongoing.

Between May and December 2014, a total of 53 cases of human rights violations were documented by the REAct system in Uganda. Unfortunately, a lack of resources has complicated efforts to follow-up all clients to establish longer-term impact, although anecdotal evidence suggests it has made a significant contribution to the welfare of MSM, and the intervention is held in high regard by the community.

Staff from SMUG, the REAct system is soon to be rolled out in Zimbabwe. While GALZ has been involved in collecting data on human rights abuses through a previous system, REAct will enhance their capacity to document and respond to reported violations.

For more information about REAct, see: http://tinyurl.com/nzw4ngl
5.2.2 Encouraging supportive communities

Interventions within this category are typically associated with trying to reduce the stigma associated with homosexuality among the wider community (e.g. not among MSM themselves). By tackling such stigma, dispelling myths and making people aware of the specific health needs of MSM, it is hoped that targeted HIV prevention, treatment and care interventions can be delivered more safely and effectively. Such interventions are often delivered as part of events, such as World AIDS Day or IDAHO, or are part of targeted one-to-one or group interventions with family members. Aims and objectives of interventions that encourage supportive communities are presented in Table 5.2.

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives (such as the following)</th>
</tr>
</thead>
</table>
| To increase knowledge of the specific health needs of MSM | A higher proportion of the general population understand that HIV and STIs disproportionately affect MSM  
A higher proportion of the population understand that stigma can be a barrier to MSM accessing health services |
| To raise awareness of the existence of and value of MSM within communities | An increased proportion of the general population understands that MSM are present in all sections of human societies and cause no harm  
The increased proportion of the general population recognizes the valuable contribution that MSM (as is the case for all other men) can make to society |
| To dispel myths about MSM social and sexual interaction | The wider community no longer stigmatise MSM in accordance with inaccurate beliefs about sexual practices |
| To develop a supportive family environment for MSM | Relations between MSM and family members who might have previously rejected them can be restored.  
A network of accepting family members of MSM is developed to provide peer-based support to parents and family members. |

**Strengths**

- **Engaging environments.** Many of the activities connected with this form of intervention take as their starting point an engaging social activity to which members of the community may feel benefit in participating (e.g. a party, parade, lunch etc.).

- **Acknowledging social/cultural forces.** The key strength of this approach is that it recognises the role that communities (operationalised at every level) can play in individual thinking and behaviour. It recognises that interventions to improve the health and well-being of MSM are unlikely to be effective if they do not take account of the wider environment within which MSM live, interact, and seek to access health services.

- **Importance of the family environment.** CBOs recognise the deep cultural importance of the family environment for the well-being of many MSM within their societies. They are developing a concrete set of approaches to re-engaging with MSM’s family members, despite the challenges this presents. For example, in Tanzania a parent-to-parent network is being established so that parents who are supportive of MSM will be put in touch with those struggling. In Zimbabwe, where the approach is based on a theoretical and therapeutic approach in partnership with the Institute for Family Therapy, GALZ attempts to find at least one supportive family member who can be supported to help promote acceptance through a man’s family.
Capacity for impact

- **Focus of intended change.** While significant in scope, most interventions of this type are focussed on a fairly narrow range of aims. This can help to ensure the greatest likelihood of impact with limited resources.

- **Supportive local neighbourhoods.** CBOs such as HOYMAS and SANA have reported that they have good relationships with their neighbours, something that many other CBOs actively seek to foster by engaging in activities benefitting the community at large. These CBOs report that the local community engages with them in a practical manner, for example coming to take HIV tests at their office clinics. That CBOs are able to promote at least some level of support in their immediate environment suggests that the wider population has the potential to become more supportive through increased familiarity with, and exposure to, homosexuality.

Challenges to implementation

- **Safety of staff and volunteers.** Events that involve CBO staff or volunteers engaging the wider population around issues relating to homosexuality leave them exposed to insult or injury from that population. It requires they be publicly open about their own sexual orientation and can threaten their own social stability. There is therefore a great tension between the need to promote visibility and awareness of MSM within the community in order to effect change, and the need to ensure that MSM will be safe at the offices and at events.

- **Scale and opportunity.** Currently, interventions specifically aspiring to encourage supportive communities for MSM are not common. In many instance they are combined with interventions outlined in section 4.3.1, or only occur on a sporadic basis.

- **Opposing forces.** The task of shifting public perspective of MSM is enormous – well beyond the means of one organisation. There are often opposing social, religious or political forces in each locality which seek to propagate myths around homosexuality and maintain the stigma associated with MSM. As discussed in the background to this report, public opinion is extremely unsupportive of homosexuality and this is taken advantage of by political populism in these countries. Having, or establishing, an impact in such circumstances is extremely challenging.

CASE STUDY 10  **Youth on Rock Community support intervention**

In 2013, the Youth on Rock Foundation (a subsidiary, grassroots SHARP partner in Uganda) staged an intervention whereby members of the local MSM population performed a number of socially responsible tasks in the community, such as collecting litter and clearing drainage ditches. They were clear to inform the local community that this work was being by men who have sex with men (or gay men). The aim was to highlight how MSM are a part of the community and how they can, and do, play a valuable role in society. This specific, small-scale, project was funded by the Norwegian Embassy in Uganda. Similar work has also been conducted previously by CHESA in Tanzania, as well as HOYMAS in Kenya, who painted a health facility in Nairobi that their members are referred to.

Poster title: “New HIV infections among key populations is five times that of the general population, we need collective efforts to eradicate HIV in order to obtain the Three Zeros”. Strapline: “Public services are the right of everybody regardless of gender or sex.”
5.2.3 Sensitisation of religious, traditional or other community leaders

A small number of interventions fell into this category, which typically involve sensitising community or other key opinion leaders as to the existence and value of MSM within society, and their specific health needs. Much of the work in this area is informed by the International HIV/AIDS Alliance ‘Empowerment for Advocacy’ (EMPAD) document. This is a policy framework for national advocacy with and by key populations and includes advice on how to devise new advocacy interventions or communicating advocacy work around key populations. In the case of SHARP, such interventions have similar aims and objectives to those described in the preceding section, however the overarching goal here is to achieve wider dissemination of this information about MSM through the networks of people who occupy these influential positions. The strengths and challenges associated with such work are broadly similar, however an additional point relating to capacity for impact is the careful selection of groups and social structures who have influence in local communities.

**CASE STUDY 11 MAAYGO Sensitisation of local chiefs**

In 2014, following a series of attacks and a raid on the MAAYGO office which resulted in the arrest of MAAYGO’s Director and Finance Officer, MAAYGO embarked on a sustained campaign of sensitising decision makers and officials in and around Kisumu. For example, a large event was held by MAAYGO whereby 49 local chiefs (elders) from Kisumu County in Western Kenya received sensitisation training around MSM. Their aim was to create a safe, neutral space in which the chiefs could discuss their perspectives on homosexuality and where MAAYGO staff could dispel common myths or uncertainty.

The intended outcomes were that chiefs would: understand the public health regarding HIV among MSM; recognise that MSM are an integral part of every community; understand that all MSM have human rights enshrined within the constitution and have a right to privacy. They also sought to explain the circumstances in which homosexuality is illegal in Kenya (i.e. being caught in the act of anal intercourse with another man, rather than a homosexual or gay identity).

5.2.4 Policy advocacy & lobbying

Most SHARP partners engage, to greater or lesser extent, in lobbying of policy/decision makers and/or members of local government, members of parliament and government ministers. Depending on the level of engagement, such advocacy and lobbying may aim to ensure the greater inclusion of MSM in health and social care programmes, greater resourcing of interventions addressing needs of MSM, or mention of MSM within relevant HIV or sexual health policy. It may also involve lobbying that relates to more fundamental aspects of human rights for MSM, including efforts to prevent further criminalisation (such as the AHA in Uganda). Policy advocacy and lobbying interventions may take place in a semi-public meetings to which a number of minority parties are invited (e.g. such as establishment of new national HIV prevention guidance) or in more private, one-to-one meetings with key stakeholders. Typical aims and objectives of these interventions are described in Table 5.3.

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TABLE 5.3 Aims and objectives of policy advocacy and lobbying interventions

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that legally enshrined rights of MSM are established and upheld.</td>
<td>The health needs of MSM are understood by policy and decision makers in terms of the right to health as granted to all citizens.</td>
</tr>
<tr>
<td>To ensure that the health needs of MSM are reflected in HIV policy guidance and activities at the national level.</td>
<td>National HIV strategies and plans recognize the need for appropriate HIV prevention and care services for MSM.</td>
</tr>
<tr>
<td></td>
<td>Policy and decision makers recognize the deleterious effects of anti-homosexuality legislation, policy or practice in terms of combatting the spread of HIV</td>
</tr>
</tbody>
</table>

**Strengths**

- **Identification of supportive partners/individuals.** All CBOs have managed to identify organisations with whom they have been able to partner in order to promote the health of MSM. For example, SMUG were able to form a broad coalition of civil society and rights organisations to work in partnership to achieve the annulment of the AHA. Both ISHTAR and MAAYGO have formed valuable relationships with LVCT in their respective cities who they now work with to facilitate outreach and increase HIV testing. All SHARP CBOs are engaged with some form of national HIV prevention policy planning forum, but often their participation has only been possible because of strong, trusting connections with key individuals in ministries or AIDS control programmes who are willing to act as MSM advocates.

- **Framing.** CBOs, being very aware of the social and political context in which they are situated, are advocating for the right of MSM to health as the right of all citizens of their respective countries. Educating themselves and developing partnerships with legal organisations, they are ensuring that their arguments can be based on existing legal frameworks.

- **Developing long-term strategic plans.** CBOs such as GALZ and SMUG are engaged in developing advocacy plans that are considered strategically over long timescales, and recognise the necessary enabling environment for each step and the appropriate means by which MSM’s rights and health promotion should be framed.

- **Data collection for monitoring and intervention design.** In addition to the emergency response facility, described in case study 9, REAct supports data capture for evidence-based advocacy and informing HR programming interventions as well as research. This system is currently used by four organisations (SMUG, IBU, GALZ and Spectrum Initiatives) over two countries (Zimbabwe and Uganda) and provides, for the first time, a standardised approach to recording human rights violations experienced by MSM.

**Capacity for impact**

- **Advocacy achievements with local authorities.** It should be recognised that the ability of CBOs to carry out many of their activities, including mapping of hotspots and mobile clinic services provision, establishment of clinics and even activities held at local offices is facilitated by advocacy conducted at the local level. In order to conduct these activities and to expand to new neighbourhoods, CBOs have had to make initial contact with municipal officials and then to continue to send reports and to document their health promotion activities in order to avoid accusations of ‘promoting homosexuality’. That they have been able to achieve this at the local level and to maintain these relationships is a positive sign for further expansion of geographical reach to MSM and also potentially to policy reach within government.

- **Expert source of information.** Many of the CBOs (especially GALZ and SMUG) have achieved success in establishing themselves as expert sources of information about LGBT and MSM communities. While having to be careful about not disclosing information that could prove detrimental to the communities, CBOs can fulfil a need in providing expert advice on HIV prevention issues among key populations, which is increasingly valued in the changing donor funding environment.
Challenges to implementation

- **Access.** Given the governmental level of homophobia that exists in SHARP countries, it can be hard for MSM organisations to gain access to key policy and decision makers. Often their requests for meetings are refused or ignored or they are not invited to key policy development meetings. A regular turnover of elected officials can exacerbate this problem, as new relationships have to be formed.

- **Safety and security.** An issue reflected in previous sections of this chapter, by virtue of their approach to senior decision makers or members of the government, the CBO staff leave themselves exposed as MSM, or MSM advocates. This can place them in danger and care has to be exercised as to how the approach is made and where meetings take place.

**CASE STUDY 12  SANA Documentation of human rights abuses**

In Tanzania, SANA partnered with Human Rights Watch through the Wake Up and Step Forward Coalition (WASO) in the research and production of a report on human rights abuses against vulnerable population in Tanzania. This culminated in the publication in 2013 of *Treat Us like Human Beings: discrimination against sex workers, sexual and gender minorities and People Who Use Drugs in Tanzania*. The report documented violations by the police, within the health sector, towards minors, towards those most at risk of HIV and made recommendations. As a result, SANA was invited by the Tanzania Commission for AIDS (TACAIDS) to address Parliament as to the health needs of key populations in Tanzania. SANA reported that while some MPs were unsupportive, other MPs were receptive to their message, particularly expressed as the need to fulfil rights to health and education granted to all Tanzanians. This case demonstrates a range of partnership types – collaboration across MSM organisations in WASO, partnership with international NGOs in Human Rights Watch, engagement with national government and an example of the effectiveness of documenting human rights abuses as an advocacy and profile-raising tool.
6. SERVICE LEVEL INTERVENTIONS

This chapter explores interventions that seek to influence and improve services that MSM access and engage with and which are external to the CBO. For example, interventions delivered by CBO staff to the workforce of other organisations, such as those within healthcare settings, but also interventions that engage with law enforcement and legal services. Interventions that are delivered on a 1-to-1 or group basis within the CBO (such as an on-site clinic) are described in Chapter 4.

As in previous chapters, we begin by examining the methods by which CBOs engage with service providers, then give an intervention typology overview and then examine the aims, objectives, strengths, challenges and capacity for impact for each intervention type.
6.1 ENGAGING SERVICE PROVIDERS

To influence the services provided to MSM, CBOs first must develop strategies to engage them. This has occurred in the following ways:

- CBOs approach service providers:
  - Direct physical approach, such as going to visit health clinics when moving to, or visiting, a new location;
  - Drafting letters/emails to all clinics in a locality and engaging with those who respond;
  - Writing to local government authorities who commission or manage services when moving to work in a new area.

- Service providers approach MSM CBOs to assist them in reaching MSM.
- Forming partnerships with organisations via personal relationships between individuals
- Mutual engagement in policy processes, such as drafting of national strategic plans

CBOs have noted that the increasing recognition of the need to engage with key populations has incentivised service providers to work with them, though challenges emerge if this engagement is tokenistic.

6.2 OVERVIEW OF SERVICE LEVEL INTERVENTIONS

Service level interventions typically involve CBO engagement with organisations providing sexual healthcare, HIV testing, counselling/therapy services, legal services, law enforcement and NGOs providing relevant support for the general population. The process and nature of engagement is determined by the local political, financial and cultural circumstances, and can be clustered into the following intervention types.

1. Mapping, vetting and monitoring of existing services for referral: identification and verification of health or legal services to which MSM can be referred to safely.

2. Sensitisation training of service providers: typically involves CBO staff working to improve service provision to MSM by conducting sensitisation training with staff of health or legal services.

3. Development and adaption of training materials: In order to provide training that is appropriate to their local contexts, CBOs are also involved in producing and adapting sensitisation training materials.

Given that many of the problems relating to successful implementation of the interventions are determined by successful engagement with service provider’s population in such complex social and political circumstances, they frequently share a common set of strengths and weaknesses. As such, we detail the aims and objectives of each intervention type individually, but then consider the strengths, capacity for impact and challenges collectively.

6.2.1 Mapping, monitoring and vetting of service providers

In order to provide MSM with a greater range of service provider options, extend reach beyond the CBO’s physical location or to reduce the number of services it must centrally provide, CBO’s have adopted a range of measures to select, vet and monitor service providers to whom they can confidently refer members. These procedures are most common and formalised in sexual healthcare and HIV testing and counselling, though CBO’s also form relationships with other types of service providers, including legal advisers, therapy-providers and organisations serving the needs of HIV positive people. Aims and objectives of mapping, monitoring and vetting interventions are displayed in Table 6.1.
This intervention type was a central component of work for several SHARP CBOs. Sensitising healthcare workers as to the specific health needs of MSM – and ensuring they offer safe and non-discriminatory services – is essential in ensuring longer term sustainability and legacy of the SHARP programme. A few CBOs (including MAAYGO) also undertook more limited sensitising training with members of local police forces, to try and ensure better reporting and response to cases of homophobic harassment or violent attack. Sensitising training of this type typically occurred at the premises of the service provider (e.g. the specific hospital) or at a local venue that had been hired for this purpose. Training was usually conducted by CBO staff, often supported by peer educators.

CASE STUDY 13  SANA and GALZ ‘mystery shopper’ monitoring of services

SANA and GALZ monitor the provision of services to MSM via a ‘mystery shopper’ approach. In this scenario, a CBO staff member or volunteer visits a clinic to which members are referred unannounced, as any other client would. Their aim is to examine whether the clinic is in fact providing a good service to MSM. GALZ has used this approach as part of an evaluation of sensitisation training, visiting clinics where healthcare workers have previously received training and which should then be friendly and competent in serving MSM. SANA has described taking this approach in response to reported problems at a clinic and as part of a strategy to highlight problems to the service provider.

6.2.2 Sensitisation training of service providers

This intervention type was a central component of work for several SHARP CBOs. Sensitising healthcare workers as to the specific health needs of MSM – and ensuring they offer safe and non-discriminatory services – is essential in ensuring longer term sustainability and legacy of the SHARP programme. A few CBOs (including MAAYGO) also undertook more limited sensitising training with members of local police forces, to try and ensure better reporting and response to cases of homophobic harassment or violent attack. Sensitising training of this type typically occurred at the premises of the service provider (e.g. the specific hospital) or at a local venue that had been hired for this purpose. Training was usually conducted by CBO staff, often supported by peer educators.

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve access to quality and non-discriminatory HIV and sexual healthcare for MSM</td>
<td>To develop and maintain list of sexual health and HIV clinics to which MSM can be referred that CBOs are confident will be friendly and understanding of them and their needs.</td>
</tr>
<tr>
<td></td>
<td>To make clinic management aware of any problems with staff being homophobic so that they can be addressed.</td>
</tr>
<tr>
<td></td>
<td>To improve the attitudes and understanding of healthcare providers towards the needs of MSM.</td>
</tr>
<tr>
<td></td>
<td>To reduce the likelihood that MSM will suffer harassment and ill-treatment when they try to access healthcare.</td>
</tr>
<tr>
<td>To ensure sustainability and mainstreaming of services for MSM</td>
<td>To ensure safe referral pathways for services that that MSM require but which cannot be provided centrally by the CBO.</td>
</tr>
<tr>
<td>To improve access to quality and non-discriminatory legal advice for MSM</td>
<td>To refer MSM to legal organisations and lawyers who will support them.</td>
</tr>
</tbody>
</table>
### Table 6.2 Aims of sensitisation training interventions

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve knowledge and skills of providers relating to the specific healthcare needs of MSM</td>
<td>To make healthcare providers aware of the specific healthcare needs of MSM</td>
</tr>
<tr>
<td></td>
<td>To reduce the likelihood the MSM will suffer harassment and ill-treatment when they try to access healthcare.</td>
</tr>
<tr>
<td></td>
<td>To expand the manner in which healthcare providers consider gender and sexuality and challenge assumptions of heterosexuality</td>
</tr>
<tr>
<td>To increase confidence in reporting of, and response to, homophobic harassment or violent assault</td>
<td>Police and law makers more attentive and responsive to security situation of MSM</td>
</tr>
<tr>
<td></td>
<td>Police and law makers more knowledgeable and responsive to human rights of MSM</td>
</tr>
</tbody>
</table>

### Case Study 14 MAAYGO Healthcare worker sensitization training

Over the last 2 years, MAAYGO have conducted a number of training sessions with healthcare workers at the local hospital. Their principle aims are to increase understanding of the specific health needs of MSM, and improve recognition of the fact that all Kenyans have a universal right to healthcare, regardless of sexual orientation. Rather than trying to engage a small proportion of workers at multiple sites, they opted to sensitise all workers (i.e. not just doctors and nurses) at just one, local state-run hospital. They also seek to serve the training to the same individuals on several occasions, allowing them assess how knowledge, understanding and clinical practice has developed over time. While their initial engagement with the hospital was challenging, good relations with the national AIDS control authority representative helped to ensure access and uptake of their training. While initial questions from staff were often awkward, a consequence of curiosity relating to MSM sexual practices, there is evidence of trust and respect developing with continued investment of time and energy.

The ongoing engagement with both management and staff (and getting their feedback and advice) at the hospital allowed them to sensitise staff fist at the STI clinic and then across other departments at the hospital. The hospital asked MAAYGO to base peer educators at the hospital to welcome and guide MSM through the offered services and later asked MAAYGO to conduct their sexual health discussions at the hospital. This allows the discussions to happen in a safe space, where services are on site and also has allowed management and staff to attend and participate in the discussions so they can learn more about the realities, experiences and needs of this key population.

### 6.2.3 Development and adaptation of training materials

Intrinsically linked to sensitisation training interventions described above, a few CBOs (including GALZ and SANA) have sought to develop training materials that can be distributed outside of sensitisation training sessions to staff who deliver services to MSM. The aims and objectives of such materials mirror those of sensitisation training, but are facilitated by a different medium and may be more closely attuned to local and linguistic circumstances.
### TABLE 6.3 Aims of training material interventions

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve knowledge and skills of providers relating to the specific healthcare needs of MSM</td>
<td>To develop training materials that inform healthcare providers of the specific needs of MSM</td>
</tr>
<tr>
<td></td>
<td>To reduce the likelihood the MSM will suffer harassment and ill-treatment when they try to access healthcare.</td>
</tr>
<tr>
<td></td>
<td>To produce materials appropriate to the local contexts and in the local language</td>
</tr>
</tbody>
</table>

### 6.3 INTERVENTION APPRAISAL

#### Strengths

- **Partnership building and working within coalitions:** This process has not been without its challenges, as discussed further below, but all of the CBOs have been successful in developing and maintaining relationships with service providers of various kinds.

- **Monitoring of client healthcare experiences:** CBOs are invested in ensuring that they have up-to-date information about which providers, particularly healthcare clinics, are currently providing MSM friendly services. They are able to do this through the 1-to-1 relationships that MSM have with peer educators through which information can be relayed, and through more pro-active schemes such as “mystery shoppers”. Peer educator testing of services is done routinely by GALZ and by CHESA, including to assess healthcare sensitisation training. CBOs are also involved in trying to address problems and provide examples where they have resolved problems with individual staff members through talking with clinic management.

- **Sustainability.** The process of service sensitisation helps to ensure that the effects of the programme can extend far into the future and expand beyond the geographical scope of the current SHARP CBOs.

#### Capacity for impact

- **Increasing the likelihood that MSM will receive good care when they attend a clinic:** If men have a positive experience with sexual healthcare and HIV testing or care once, they might be more likely to re-attend. If their experience is poor, they might be less likely, so reducing the chances of this by having a list of clinics to which men can be referred could have impact in the long-term.

- **Facilitating scale-up of geographic reach:** Partnering with other service providers, rather than providing all services ‘in-house’ seems to have enabled CBOs to operate over a larger geographical area than would have been possible otherwise. For example, GALZ works with site coordinators around Zimbabwe to provide information and services to MSM outside of the practical reach of Harare and Bulawayo. These site coordinators are able to refer MSM to clinics locally because of the clinic identification, vetting and monitoring procedures that GALZ operates.

- **Facilitating the breadth of needs that CBOs can address:** Through working with other organisations, CBOs are able to broaden the set of services they can provide safe and confidential referral to.

- **Development of training materials and approaches:** CBO’s draw on training materials from a range of sources and adapt and combine them to meet the needs of their local contexts and training circumstances. While CBO’s such as CHESA have spoken of challenges in obtaining materials that are culturally appropriate and in Swahili, they are engaged in creating a foundation for local materials and approaches. GALZ, for example, has drawn on three different training courses for sensitisation of healthcare providers in finding a programme that seems to work well for them.
Challenges to implementation

- **Engaging with government provided healthcare can be challenging initially:** CBOs have reported that support of the Ministry of Health is important for working with government clinics and the political situation can make this support difficult to obtain.

- **Partner organisation leadership can change:** While there are advantages to working with other clinics or NGOs to provide services for MSM, these partnerships are sometimes vulnerable to changes in leadership and to shifts in the political climate.

- **Influence on partner’s service provision:** Even when CBOs have systems in place to monitor the experiences of their clients at each clinic/service provider, they are not always able to persuade these service providers to take action against problems in a timely manner. Such a situation could also damage the reputation of the CBO if men continue to attend the service and experience mistreatment. One CBO has been reporting problems with harassment about clients’ sexuality by VCT counsellors at a partner organisation for two years, but the problems still continue.

- **Need for medically based training for healthcare providers:** In addition to the need to improve the extent to which healthcare workers are sensitive to MSM and treat them with dignity, there is a need for medical training on health issues relevant to MSM, such as anal STIs. In the long term, there is need for such training to be integrated into the medical training curriculum for all doctors and nurses.

- **Need for sensitisation training across the full spectrum of healthcare provider staff:** While it is more common for CBOs to have the opportunity to conduct sensitisation training with doctors and nurses, it is important to also involve other staff including receptionists and administrators who are often the first point of contact for MSM and who CBO staff report as sometimes being obstructive or dismissive of MSM.

- **Need to facilitate new prevention technologies:** It is crucial that marginalised populations, such as MSM, are not ignored in efforts to roll out pre-exposure prophylaxis (PrEP) among HIV affected communities. It is also important to advance the provision of post-exposure prophylaxis (PEP) to men who feel they may have been exposed to the virus.

- **Mental Health services:** While not formally assessed in this study, a range of mental health concerns were evident among the MSM populations. Issues such as anxiety, depression or suicidal ideation have been widely reported among MSM populations in several countries, often arising from societal stigma and internalised homonegativity. It is important that mental health services are sensitised as to the specific needs of MSM and how best to respond.

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The International HIV/AIDS Alliance and their linking organisations in each country regard community systems strengthening as a key objective of the SHARP programme. They aim to strengthen MSM CBOs and networks in the region by increasing their capacity to serve the HIV prevention, treatment and care needs of MSM. This includes resourcing and developing their capacity to devise and manage innovative programmes, and measure results.

While this appraisal did not set out to directly examine this aim, data was documented as various stages that indicates progress towards it. Such data often arose in discussion with organisational directors or management, or was highlighted by external CBOs or networks, who described how the SHARP programme had interacted with their own work. In this chapter, we briefly review these incidental findings according to the CBO internal systems, their organisational resilience and their participation in wider partnerships or networks.
7.1 DEVELOPMENT OF ORGANISATIONAL SYSTEMS

The partner CBOs report a number of ways in which SHARP has contributed to the development of internal systems at their organisations, which enhance their ability to design and deliver evidence-based interventions to MSM in their region.

- **Financial management systems.** SMUG, IBU and MAAYGO all report a marked improvement in their ability to manage their finances, including budgeting and reporting, as a consequence of training and support provided by the Alliance and their linking organisation. While some organisations struggled to handle cash flow and budget appropriately in the initial phases of the programme, and while there were occasionally sensitivities between Linking Organisations and CBOs, these seem to have been overcome and most feel their competency in this area has improved over the past 2 years.

- **Unified monitoring system.** The adoption and implementation of the SyrEX system was widely appreciated by partner CBOs, reporting that it made it easy to verify that the information they were collecting about their programmes was correct, and they considered it favourably in comparison to monitoring systems from other donors. Although significant time and energy was required to integrate this system with existing organisational practices, all who now use it felt it had improved their ability to record and track interactions with clients. This can enable assessment of service provision, continuity of support to individuals and also supports programme management decisions and facilitates reporting of activities to donors. Finally this also allows for generation of data for evidence-based advocacy.

- **Establishing critical mass for interventions.** CBOs including ISHTAR, CHESA and GALZ described their belief that resources provided by SHARP had enabled them to scale-up small or pilot-stage interventions that were previously in place. Interventions such as CBO based clinics are only likely to be successful once they can open at the times and in the places where MSM would like to receive their services. SHARP appears to has enabled this. In the case of GALZ and IBU, SHARP was praised as having enabled them to expand their geographical reach.

7.2 DEVELOPMENT OF ORGANISATIONAL RESILIENCE

Linked with the development of organisational systems, many CBOs felt that participation in SHARP may have improved their resilience in the longer term.

- **Enhancing capacity to secure future funding.** Development of organisational financial systems, as well as programming and reporting mechanism meant that some CBOs (especially SMUG, IBU and MAAYGO) felt better prepared to apply for funding to other donors. While yet to be determined, this may help to ensure the longevity of these organisations.

- **Internal systems and structures.** Partner CBOs frequently voiced their frustration that most international donors would only provide funding for specific projects, rather than also support organisational infrastructure or programme development. This was contrasted with SHARP, which provided organisation and staff development linked with ongoing, and new, programmatic activity.

- **Security and safety.** SHARP provided contingency planning and resources for safety and security of all partners (e.g. the installation of enhanced security at the offices of SMUG and legal retainers for the Uganda partners). This has helped to ensure the safety of staff and visitors, and ultimately ensured continued activity of the organisation.

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55SyrEX is a system of programme and intervention monitoring, devised by the International HIV/AIDS Alliance.
Partly as a consequence of engagement with the LO in each country (with exception of GALZ) and of their participation in this regional partnership programme, the CBOs described how their involvement in SHARP had helped them to develop local, national and regional partnerships.

- **Accessing national policy structures.** Prior to the commencement of the SHARP programme, ISHTAR, CHESA, GALZ, IBU, and SMUG had developed relationships (formally and informally) with their national HIV control organisations and participated in policy development, while the others had not. In these latter instances, the linking organisation was able to facilitate access to such policy structures and thus enhance MSM representation at the national level.

- **SHARP as an MSM network.** CBO staff and volunteers were overwhelmingly positive about their experience of SHARP partner meetings, including the opportunity to meet other MSM organisations in the region to share best practice and new ideas. There have already been several cross-organisational visits to share expertise, with more planned or hoped for the future.
The following recommendations are derived from the process of intervention appraisal as well as reflections on efficacious interventions published in the peer reviewed literature. These recommendations should be considered alongside the case studies presented throughout the report, which describe successful interventions that we believe to be essential components of the programme as it moves forward. These approaches should be replicated in each country wherever possible.
8.1 RECOMMENDATIONS FOR INDIVIDUAL LEVEL INTERVENTIONS

1. While SHARP has demonstrated considerable success in serving the sexual health needs of MSM between the ages of 20 and 30, this group does not likely comprise the majority population of men who have sex with men in each of the 4 countries. There are considerable barriers to engaging MSM over the age of 30 but doing so should be considered a priority for future intervention planning. While there are limited examples of promising practice to share across the region, CBOs may look to MSM CBOs in other developing country settings for advice or resources in engaging this age group. However, engaging older men should ideally not result in the re-direction of resources and interventions away from younger MSM, who remain a priority target group and with whom success of reach has been achieved.

2. There are clear challenges for peer educators in carrying and disseminating materials to men they encounter. Workers identified linguistic and language barriers to understanding and using written materials. Given the rising use of mobile phone technologies, funders might consider the resourcing of short videos or podcasts that could either be downloaded independently by MSM, or could be used by outreach workers to illustrate or describe HIV or STI prevention information. Consideration should be given to providing skills building and training of SHARP projects in the production of such media interventions. However, further consideration should also be given to facilitating a broader development of video materials, which could then be developed by local partners – for example, central provision and development of appropriate video imagery, with a script that could be adapted or tailored for a particular regional dialect, or local area. The same could be undertaken for short podcasts.

3. Peer educators are the primary means through which contact is made with MSM and interventions are delivered. SHARP CBO partners and other organisations who engage with MSM have invested resources in their training and typically provide them with expenses to cover travel and phone costs. However, there remain unmet training needs and, as is seen in many other settings that rely on volunteer peer educators, longer-term contribution to the programme can be difficult to balance with the need to earn a living. While most peer educators acknowledged the lack of resources for them to be paid, funders could consider non-financial incentives (such as bags or clothes) and/or the establishment of a professional, certified training pathway.

4. While a small number of organisations have developed small-scale holistic sexual health interventions, many others operate mainly (or entirely) from a disease avoidance perspective. Research from a number of settings indicates that MSM are more likely to engage with CBOs and sexual health interventions on a continuing basis if they help MSM achieve satisfying or pleasurable sex lives. While the prevention of HIV is the key goal, interventions that do while attending to the broader dimensions of sexual health, satisfaction and pleasure may be more effective. Promising practice within the programme (such as interventions at MAAYGO) or those outside (such as HOYMAS) should be examined for replication or scale-up.

5. Availability of water-based lubricant is a common concern across all SHARP countries. Additionally, there is usually only one form of condom available that MSM can freely access. Evidence from many settings indicates high rates of condom failure (breakage or slippage) among African men, which can be addressed by providing a broader range of condoms of different sizes and materials. Where resources allow, CBOs should consider advocacy for a broader range of condoms (and lubricant) to MSM, which may help to reduce condom failure while also helping to ensure repeated engagement with the CBO in order to access such valuable commodities.

6. With exponential growth of mobile technology and smart phone coverage within Eastern and Southern Africa, interventions with marginalised communities conducted online have become a real possibility and should be prioritised for development. SHARP partners have trialled social media use in a variety of ways but there is capacity for expansion. There is a pressing need for research to inform the acceptability and feasibility of delivering a broad range of intervention types (with differing aims) in online social spaces. It is also necessary to conduct a workforce development assessment to identify training needs of providers and maximise the potential of these new technologies.
7. While there have been significant calls for funding of economic empowerment interventions for MSM (especially those who sell sex), caution should be exercised in resourcing such work without further research. Large scale impact evaluations of economic empowerment projects have frequently failed to establish a clear link with reduction in HIV incidence among affected communities. Those that have demonstrated promise have been preceded by in-depth qualitative research to understand need and a means of selecting those individuals best suited for the intervention.

8.2 RECOMMENDATIONS FOR COMMUNITY & STRUCTURAL LEVEL INTERVENTIONS

8. CBOs should seek to capitalise on the increasing recognition of the importance of key populations within the HIV prevention, treatment and care sector. Emphasising their roots within the MSM community, and their MSM leadership is central to this. While CBOs have valid concerns about being treated tokenistically, the pressure from supportive Ministry of Health staff and the pressure coming from donors and the HIV sector more broadly has provided greater opportunities for MSM to engage in health policy processes, including Global Fund processes.

9. CBOs should be supported in increasing their efforts to utilise research to make arguments about the importance of providing for the health needs of MSM. For example, access to lubricant in Tanzania has been restricted through the argument that it is not a health promotion technology. Access to research and/or researchers to counter this argument could be beneficial.

10. The SHARP programme, and individual CBOs, may wish to consider the extent to which the advocacy functions of the CBO versus the service provision aspects of the CBO are compatible. While both are important and mutually supportive in the long-term, in some contexts, a strong advocacy profile might increase the risks to service provision when conducted under the same name at the same premises. It is possible that providing services under a different organisational name or umbrella might protect the service provision interventions from political backlashes. On the other hand, there might be advantages in keeping all functions together. This is an issue that requires regular review.

8.3 RECOMMENDATIONS FOR SERVICE LEVEL INTERVENTIONS

11. Linking to frustrations expressed by CBO staff and peer educators that were outlined in Chapter 4, consideration should be given to expand the current programme of sensitisation training to other social care organisations in each country. The existing MSM CBOs cannot meet all health and social care needs of the MSM population by themselves. While it is understandable that many MSM may desire and expect their varied and complex needs to be met by those organisations they know to be set up and funded specifically for MSM (still an exceptional outcome in and of itself), limited resources mean most have to focus on HIV, sexual health or human rights. CBOs with experience sensitising health care providers to the needs of MSM should consider seeking resources that could enable them to conduct similar training with organisations that address housing, poverty, employment, or nutrition. These efforts could be combined with geographical expansion, in order to ensure that MSM living far away from CBO offices are able to access services.

12. CBOs might consider formalising their relationships with service providers where possible. Developing service level agreements (SLAs) could help to clarify expectations for both parties, provide a mechanism
13. CBOs could derive additional benefit from their clinic/service-provider monitoring activities by establishing an accreditation scheme. Health and social care providers meeting an agreed and mutually developed set of criteria could be accredited and display a small logo that would be recognisable to MSM, who could then be confident interacting with that service provider. The accreditation scheme could include a supportive package available to service providers, such as training schemes similar to those currently being undertaken. A regular monitoring and re-appraisal schedule should be included, which could be combined with multiple certification levels. In the United Kingdom, ‘Pride in Practice’ has been developed through a collaboration between the Lesbian and Gay Foundation and NHS North West for general practitioner surgeries (http://www.lgfu.org.uk/prideinpractice). This scheme includes bronze, silver and gold levels that GP surgeries work towards achieving alongside access to a range of supportive services for that surgery and for their LGBT patients. Such a scheme would need to be adapted for the settings in which CBOs work and involving service providers in the development of such a scheme, helping to ensure their buy-in.

14. CBOs collect information about the experiences of clients at service providers and then feedback to other MSM at the point at which they refer them to services. Social media and other web-based tools could provide an additional platform for MSM to review services. As CBOs are reviewing their ICT engagement, they could consider incorporating tools for men to look up recommended service providers and to rate them according to their experiences.

15. Collaboration with medical schools and other professional training academies is another long-term approach to improving the service provision to MSM. In Kenya and Uganda there are informal relationships between supportive individuals in professional training roles and SHARP CBOs. Curriculum review processes might also provide an opportunity for engagement.

16. The success of all of these suggested intervention developments will be contingent upon continued support for organisational development and capacity building. SHARP has invested significant resources in the infrastructure of community based organisations, helping them to better manage programmes and finances and putting them in a stronger position to secure further funding in the future. This is an approach that other programmes addressing the HIV prevention and care needs of key populations should seek to replicate.

8.4 RECOMMENDATIONS FOR FUTURE RESEARCH

8.4.1 Opportunities for evaluation of discrete interventions

a) Different models of providing access to HIV testing, and sexual health care: office-based clinic, referral to friendly services (e.g. PASADA), mobile HIV testing caravan with TAPP

Across the programme, CBOs use a variety of approaches to engage MSM in HIV testing and counselling, and to provide sexual health care and advice. There are wider debates about the best way of providing these services to marginalised populations, but there is currently little research to inform which of these methods is more successful than others. As the SHARP organisations are able to collect information about the clients using these different services, and because they are already maintaining engagement with clients over time, it should be useful and feasible to: i) compare the characteristics of MSM accessing testing and care through these different methodologies; ii) compare the health outcomes and engagement with care over time (e.g. repeat HIV testing, linkage to care).
b) Evaluating healthcare worker training

As an example, GALZ has developed approaches to healthcare worker trainings in Zimbabwe (for doctors in Harare and Bulawayo under SHARP, and then for provincial hospital workers under GFTAM). There is also interest in doing this in Tanzania, as well as a need (e.g. reported problems with HIV counsellors). SHARP organisations should be in a good position to evaluate the effectiveness of their trainings because they have clients who can report back their experiences and who are followed over time.

GALZ have also developed a fairly standard approach to assessing new clinics and whether they think they will be friendly to their clients (and then following them up afterwards). Their experience could be brought together into a ‘clinic auditing tool’, that could be tested and evaluated elsewhere or as part of a healthcare worker training package, particularly as SHARP organisations are expanding geographically beyond the reach of their own offices or know friendly clinic.

c) Emerging approaches to supporting HIV positive men

HIV positive men in all countries face many challenges, with a high level of fear of disclosure and lack of income and food security that make adhering to antiretroviral therapy very difficult, even when it was theoretically accessible. Organisations such as PASADA and ISHTAR note that about half of MSM who test positive at their clinic do not return. SHARP organisations are trying different approaches to improving this situation, including developing/hosting support groups and encouraging small scale entrepreneurship. Particularly in Tanzania, these activities are quite new/in planning stages. The evidence on income generation, such as microfinance and loans, is mixed for other populations and the most effective approach for MSM in the SHARP countries is not known. Both SHARP organisations and PASADA follow their clients over time, which could allow us to compare different approaches to make recommendations for further scale-up.

d) HIV post-test club

ISHTAR run an interesting intervention whereby they encourage all men testing for HIV to attend a series of health education events after they test. Within these they discuss safer sex techniques, relationship advice, sexual pleasure, and the impact of HIV stigma. Some of the participants will have been diagnosed HIV positive and some will not. The principle intended outcome is reduced stigma and discrimination toward HIV positive MSM, as well as increased HIV testing rates and reduced sexual risk behaviour. This intervention lends itself well to a standard before-and-after evaluation.

8.4.2 Formative research possibilities

A great many of the interventions described in Chapters 4-6 are designed and implemented without access to basic information relating to the needs of the population. This acts as a significant barrier to targeting interventions towards those most at risk of HIV exposure. We recommend a comprehensive HIV prevention, care and human rights needs assessment of MSM in East Africa. This could be conducted both on and off-line, facilitated via social media as well as existing face-to-face outreach networks. This could include, as a minimum:

- Men’s experience of condom usage and condom failure and understanding of HIV prevention technologies, (including access to, and use of, water based lubricant)

- Knowledge and awareness of: HIV prevalence; prognosis if diagnosed positive; benefits of testing; routes of transmission and means of avoiding it

- Perceptions of risk, and safer sex behaviours

- Motivations and barriers to HIV testing and STI screening

- Barriers to retention in care and ART adherence among men diagnosed HIV positive

- Engagement in sex work, and facilitating factors

- The collection of comprehensive demographic information to allow comparison and more effective targeting of interventions.
Appendix A

SHARP INTERVENTIONS APPRAISED

The table below displays all of the interventions appraised via the process outlined in section 2.3. As it is often the case that multiple interventions occur within the same setting (e.g. education about HIV testing provided at the same time as condom distribution), they are described in terms of activities. The interventions comprising each activity, and their aims were determined as part of the appraisal process.

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<thead>
<tr>
<th>Country</th>
<th>Organisation</th>
<th>Activity</th>
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<tbody>
<tr>
<td>Kenya</td>
<td>ISHTAR</td>
<td>Face-to-face outreach</td>
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<td></td>
<td>ISHTAR</td>
<td>Events (LGBT parties)</td>
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<td></td>
<td>ISHTAR</td>
<td>Online (social media) outreach</td>
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<td></td>
<td>ISHTAR</td>
<td>Wellness centre (drop-in, inc. VCT)</td>
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<td></td>
<td>MAAYGO</td>
<td>Face-to-face outreach</td>
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<td></td>
<td>MAAYGO</td>
<td>Sensitisation training</td>
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<td></td>
<td>MAAYGO</td>
<td>WAD &amp; IDAHOT events</td>
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<td></td>
<td>MAAYGO</td>
<td>Radio show</td>
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<td>Uganda</td>
<td>SMUG</td>
<td>REAct</td>
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<td>SMUG</td>
<td>Punitive law policy analysis</td>
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<td></td>
<td>SMUG</td>
<td>Advocacy and lobbying</td>
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<td></td>
<td>IBU</td>
<td>Youth dialogues</td>
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<td></td>
<td>IBU</td>
<td>Face-to-face outreach (responsive)</td>
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<td></td>
<td>IBU</td>
<td>Regional outreach and VCT</td>
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<td></td>
<td>IBU</td>
<td>Drop-in centre (inc. VCT)</td>
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<td></td>
<td>IBU</td>
<td>Wellness support for PLHIV</td>
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<td>Tanzania</td>
<td>CHESA</td>
<td>Face-to-face outreach</td>
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<td></td>
<td>CHESA</td>
<td>Mapping of hotspots</td>
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<td></td>
<td>CHESA</td>
<td>Peer-to-peer discussions</td>
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<td></td>
<td>CHESA</td>
<td>Distribution of condoms and lube</td>
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<tr>
<td>Tanzania</td>
<td>CHESA</td>
<td>Drop-in centre</td>
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<td>CHESA</td>
<td>Mobile VCT caravan</td>
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<td>CHESA</td>
<td>ICT and social media</td>
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<td>SANA</td>
<td>Face-to-face outreach</td>
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<td>Mapping of hotspots</td>
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<td>Online outreach and social media</td>
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<td>Distribution of condoms and lube</td>
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<td>Mobile HIV testing caravan</td>
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<td>Income generation and training</td>
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<td>Advocacy and policy work</td>
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<td>Documentation of human rights abuses</td>
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<td>Zimbabwe</td>
<td>GALZ</td>
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<td>Online outreach and mobilisation</td>
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<td>Sensitisation training</td>
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<td>GALZ</td>
<td>HIV positive support group</td>
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<td>GALZ</td>
<td>Human rights reporting</td>
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<td></td>
<td>GALZ</td>
<td>Safety &amp; security training</td>
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<tr>
<td></td>
<td>GALZ</td>
<td>One-to-one counselling</td>
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