# Mapping & appraisal of HIV prevention & care interventions for men who have sex with men (MSM) in Kenya, Tanzania, Uganda & Zimbabwe

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## 1. OVERVIEW

**This report summaries an appraisal of HIV prevention and care interventions delivered by men who have sex with men (MSM)-led community based organisations (CBOs) in Kenya, Tanzania, Uganda and Zimbabwe. These interventions are implemented 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).**

**This executive summary 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. The full report can be found at http://www.aidsalliance.org/resources/669-sharp-lshtm**

## 2. CONTEXT

The best data publically available indicates that HIV prevalence is significantly higher among MSM than in the general male population in Kenya, Tanzania and Uganda. There is no publically available data relating to prevalence among MSM in Zimbabwe, although reports from community and clinical service providers indicate a similar trend.

| Country | Estimated HIV prevalence among MSM % | Estimated HIV prevalence general male population % |
|---|---|---|
| Kenya[1,2,3,4,5] | 12.3 – 43.0 | 5.1 |
| Tanzania[6,7,8] | 11.1 – 30.2 | 6.4 |
| Uganda[9,10] | 13.7 | 6.3 |
| Zimbabwe[11] | unknown | 12.3 |

Homosexuality remains illegal in each of the SHARP programme countries, hampering efforts to deliver supportive services for MSM. While there is growing willingness on the part of governments in Kenya, Tanzania, Uganda and Zimbabwe to engage with the issue of HIV among MSM, individuals and LGBT organisations still experience widespread harassment, violence and discrimination[12,13,14]. In 2014 an attempt was made to impose further, significant legal restrictions on homosexual men and women in Uganda. While this legislation was annulled in August 2014, the legal and social environment for MSM remains hostile across the four countries.

## 3. THE METHOD OF APPRAISAL

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

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.
**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.
**Service level interventions:** Those which seek to increase the capacity or accessibility of services that MSM access.


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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.

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;
4. Facilitating future, rigorous impact assessments;
5. Identifying promising (or best) practice for duplication and scale-up.

## 4. OVERVIEW OF KEY FINDINGS

While there was variation across countries and CBOs, the following sub-sections represent the key issues that emerged from our analysis at a regional level.

When giving consideration to these findings, it is crucial to take account of the political and cultural context in which the SHARP programme operates. As the main report describes in detail, MSM and the organisations that seek to serve them frequently face harassment or hostile government intervention. The activities of CBOs take place in socially conservative environments and among communities where stigma and discrimination of MSM is widespread. The successes and the current shortcomings of the SHARP programme *must* be viewed in this light.

### 4.1 Community engagement and representation

- 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 more than 14,900 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[15], 33.23% in Tanzania[16], 35.67% in Zimbabwe[17] and 21.2% of those aged 15-24 in Uganda[18]. 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 MSM 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.
- Geographic reach of interventions varies. While many CBOs have either developed or are planning strategies to provide support to men outside of large towns or capital cities, there are likely many MSM still in need of services who do not have access.

### 4.2 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 non-visible manner.

### 4.3 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. In Tanzania, an MSM CBO was de-registered as a result of their online messaging. There is currently very limited research to inform how best to position interventions within these spaces.
- SMUG and MAAYGO have developed innovative partnerships to allow radio broadcasts that seek to advance men's understanding of their health and human rights. 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.

### 4.4 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. 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 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 or diversion of resources.

### 4.5 Holistic and enabling environments

- Several SHARP CBOs 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).
- 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.

### 4.6 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 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.

The Sexual Health & Rights Programme (SHARP) aims to improve the sexual health and well-being of men who have sex with men in Kenya, Uganda, Tanzania and Zimbabwe. Partners include: The International HIV/AIDS Alliance, ISHTAR MSM; Men Against AIDS Youth Group Organisation (MAAYGO); Kenya AIDS NGOs Consortium (KANCO); Gays & Lesbians of Zimbabwe (GALZ); Icebreakers Uganda (IBU); Sexual Minorities of Uganda (SMUG); Community Health Alliance Uganda (CHAU); Stay Awake Network Activities (SANA); Community Health Education Services & Advocacy (CHESA); Tanzania Council for Social Development (TACOSODE).


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# 5. RECOMMENDATIONS

In chapter 8 of the main report 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, and these are summarised below.

## 5.1 Recommendations for individual level interventions

- 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.
- 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.
- 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.

## 5.2 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, their MSM leadership and their expertise 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.

## 5.3 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 experiences.
- 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 CBO core costs and activities as well as organisational development and capacity building.

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