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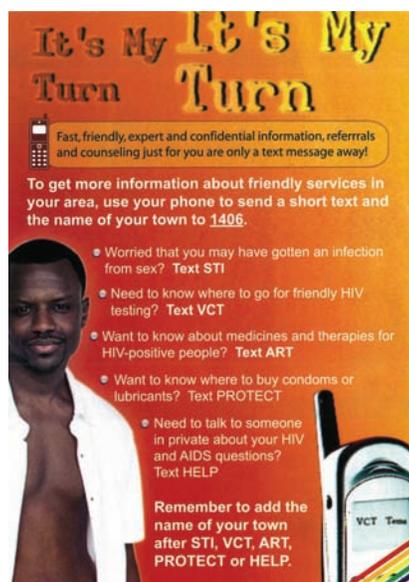


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CEPEHRG and Maritime, Ghana

Engaging New Partners and New Technologies to Prevent HIV among Men Who Have Sex with Men



Courtesy of AED/SHARP

Leaflet promoting text messaging service for MSM.

The evening is warm and humid on the coast of Ghana, and in a secluded courtyard near an urban marketplace in Takoradi, a small gathering is taking place. A handful of young men are meeting with a peer educator from the Maritime Life Precious Foundation to discuss HIV and other sexually transmitted infections (STIs). On the agenda tonight: how to protect yourself and your partner during sex, how to use a condom, and how to get tested and seek treatment when needed. HIV prevention workshops take place every day throughout the country, but this one is different. The participants are men who have sex with men (MSM), a population that faces frequent scorn and almost universal criminalization throughout Africa, and for the first time in their lives, they are learning about the serious risk they face from HIV.

Many African MSM are surprised to discover that the sex they have with other men puts them at risk for acquiring the virus. The media and most prevention programming in the region consistently describe HIV vulnerability in terms of heterosexual risk, and many African MSM do not realize that they too are vulnerable. The few programs that do target this population face significant challenges in reaching MSM with the information and services they need.

Ghana, which like its neighboring states condemns homosexuality, is distinguished from most countries in sub-Saharan Africa by the level of activity addressing HIV among MSM. With the support of the President's Emergency Plan for AIDS Relief (PEPFAR), groundbreaking HIV programming for MSM has been developed in the country. Although the Ghanaian government has not publicly embraced these efforts, officials have also not prevented the development of these interventions despite the legal prohibition of homosexual behavior.

By James Robertson

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In Ghana, civil society organizations have been at the forefront of HIV programming for MSM. Among the small number of organizations doing this work are the Accra-based Center for Popular Education and Human Rights, Ghana (CEPEHRG), a human rights group committed to advocacy for sexual minorities, and the Maritime Life Precious Foundation (Maritime) in Takoradi, which provides health education and poverty reduction activities in seafaring communities along the western coast. Both received technical assistance and funding from the Academy for Educational Development's (AED) Strengthening HIV/AIDS Response Partnerships (SHARP), a program funded by PEPFAR through USAID/Ghana from 2004 to 2009.

CEPEHRG and Maritime offer valuable lessons for program planners and managers seeking to develop HIV interventions for MSM in difficult implementation environments. In Ghana, research helped make the case for action, furnishing evidence to confirm that HIV among MSM is an urgent matter of public health. Donor support was essential, providing both necessary funding and champions to guide the development of a programmatic response without overt governmental support and in the face of skepticism and resistance. The willingness to adapt and innovate was also vital to success; as cell phones became commonplace in the country, outreach leveraged this technology to target MSM more directly. While creating these interventions was not easy, their value has been unquestionable. For MSM like those in the night-time prevention session described above, who hear for the first time what they need to do to avoid HIV infection, these efforts are quite literally life-saving for them and their partners.

Making HIV Programming For MSM a Priority

In the 1980s and into the 1990s, AIDS was largely perceived as a "gay disease," since it seemed to primarily affect communities of gay men in the United States, Europe, and other parts of the industrialized world. Many governments in the West were slow to respond to HIV among these often marginalized men, leaving community-based organizations (CBOs) to find the means to provide prevention, support, and care services. In sub-Saharan Africa, the epidemic appeared quite distinct from this paradigm, with research suggesting a different transmission dynamic. Early on, homosexual behavior was not identified as a driver of the epidemic in the region, as study participants reported no same-sex sexual activity (Piot et al. 1984). Most subsequent research avoided questions about same-sex sexual behavior, both reifying a model of the epidemic in Africa as "heterosexual" and reflecting the anxiety that homosexuality provokes in many cultures in this region as well as its typically criminalized status.

Over the quarter century since HIV was first recognized in sub-Saharan Africa, the response to the epidemic in the region has routinely failed to consider MSM in HIV program design and implementation. In many African countries, HIV interventions for MSM are inadequate or non-existent. In the absence of governmental or other support, fledgling rights

MSM are on average over nine times more vulnerable to infection than the general population.

SUMMARY OF RECOMMENDATIONS FROM GHANA FOR EFFECTIVE HIV PROGRAMMING FOR MSM

- Leverage MSM community knowledge.
- Undertake formative research.
- Pilot interventions.
- Find an appropriate balance with rights advocacy.
- Increase resource investment in HIV programming for MSM.
- Use social networks to reach MSM.
- Engage multiple partners to implement programming for MSM.
- Link MSM clients to government health facilities with health care workers trained to provide MSM-friendly services.
- Remain sensitive to social hostility and the criminal status of MSM.

movements for sexual minorities have provided a platform, albeit a fragile one, for MSM to respond to their vulnerability to HIV (Anyamele et al. 2005). However, the emerging body of data on MSM and HIV risk in the region indicates that such an approach alone is unlikely to reach the scale necessary to adequately address the prevention or service needs of MSM in generalized epidemics, where so many of these men are not easily identified (Smith et al. 2009). The box to the left shows a summary list of recommendations for effective HIV programming for MSM that emerge from the Ghana experience; a more detailed discussion of these points appears in a later section of this document.

Although often hard to reach and frequently neglected by national programs, MSM should be a priority for HIV prevention in all parts of the world. Recent studies show that MSM globally are at significantly greater risk for HIV infection than other adults of reproductive age, due to such biological, behavioral, and structural factors as unprotected anal intercourse, multiple sex partners, and criminalization of sexual relations between men. Research also indicates that MSM are vulnerable regardless of national HIV prevalence levels. Even in areas of medium to high prevalence such as parts of Asia and sub-Saharan Africa, MSM are on average over nine times more vulnerable to infection than the general population (Baral et al. 2007).

MSM and the Ghanaian Response to HIV

On June 9, 2009, the *Ghanaian Times*, one of Ghana's state-owned newspapers, ran a story with the headline, "Homosexuality is an abomination." The article describes a speech by the leader of a major religious denomination in Ghana that condemns the growing public acceptance of homosexuality and implores Christians to "stand firm against the powers of the dark and spiritual forces of evil." This article is noteworthy only because it reflects a predominant social sentiment toward homosexuality in Ghana. The country's legal system continues to criminalize sexual behavior between partners of the same sex and, not surprisingly, the HIV response in the country has not made the needs of MSM a priority.

Prevalence data reveal how profound those needs are. Like other countries in West Africa, Ghana has relatively low HIV prevalence, currently estimated at around 2 percent among adults from age 15 to 49 (National AIDS/STI Control Program 2009). On the other hand, the situation for Ghanaian MSM is bleak. Data from SHARP's 2007 behavioral and HIV biomarker survey of MSM in greater Accra (AED/SHARP 2007) reveal that just over 25 percent of respondents were HIV-positive, and fully half of the MSM studied older than 30 years were HIV-positive. Strikingly, 61 percent of the men identified themselves as bisexual. While the MSM in this study are not necessarily representative of all Ghanaian MSM, these data suggest that this population is disproportionately affected by the epidemic and that, unchecked, these levels are likely to increase, presenting a risk for MSM and their sexual partners, both male and female.

SHARP's research on MSM and female sex workers showed high HIV prevalence in both groups (AED/SHARP 2006a) and is consistent with the description of the HIV epidemic in Ghana as a low-level generalized epidemic with high prevalence among certain high-risk populations. The *National Strategic Framework 2006–2010* developed by the Ghana AIDS Commission (GAC) presents a strategy for identifying and prioritizing vulnerable groups, stating that their selection will “be based on a combination of biometric and behavioral studies.” Published in 2005 before SHARP's studies, the framework only mentions MSM once, as a vulnerable group without legal protection from human rights abuses. The vulnerability of MSM is not described or addressed elsewhere in this key document (Ghana AIDS Commission 2005).

Yet even without policy guidance, the Ghanaian government has quietly recognized the need to

respond to HIV among MSM, although it believes it must do so discreetly. The legal status of MSM makes programmatic action more difficult, and public health authorities in Ghana do not agree on the wisdom of advocacy for basic rights and decriminalization of same-sex sexual behavior as part of these efforts. SHARP's biomarker research on MSM was considered to be so sensitive by some policymakers and other leaders in the HIV stakeholder community in Ghana that they discouraged public release of the final report. Concerns were raised that the dissemination of data showing such high HIV prevalence among MSM could be used to “blame” them for the epidemic in Ghana and create a possibly violent backlash. As a consequence, the final report was never formally released, and only shortly before SHARP closed in 2009 were the main findings from the study published online (AED/SHARP 2007).

SHARP's research found that 62 percent of the MSM studied had at least one female partner in the past year, and a third had multiple female partners. Such information undermines static conceptions about the sexual lives of this population and reveals some of the complexities of sexual interactions involving MSM. It would be undoubtedly easier to undertake research and respond effectively to HIV among MSM if they were a distinct and easily identifiable population. Sex between men occurs in a myriad of different venues and contexts, and while it serves to define the identity of some, there are many men for whom it is simply a behavior and, like most sex, hidden from view.

In Ghana, most MSM do not publicly claim an identity based on their sexual behavior or orientation. Even leaders of MSM advocacy organizations, the public face of the movement to secure legal status for sexual minorities,

Marginalized and stigmatized, sex between men is frequently either relegated to the outskirts of social discourse or obscured entirely. As a consequence, HIV prevention efforts face a steep challenge as they seek to identify men in need of services.

hesitate to fully associate themselves with this cause for fear of their lives and livelihoods, using pseudonyms in the media and wearing wedding rings in daily life to deflect questions about their sexual orientation. There is a palpable sense of fear among MSM in Ghana that discourages visible self-identification with this population. While bars and cruising areas provide opportunities for some MSM to connect socially and sexually, the majority remain hidden. Marginalized and stigmatized, sex between men is frequently either relegated to the outskirts of social discourse or obscured entirely. As a consequence, HIV prevention efforts face a steep challenge as they seek to identify men in need of services.

SHARP's Support for CEPEHRG and Maritime

In early 2004, with the support of the West Africa Project to Combat HIV/AIDS and STI (WAPCAS) and the Canadian International Development Agency, Dr. Dela Attipoe, a Ghanaian public health physician working for Ghana's National AIDS/STI Control Program (NACP), released a study that described the vulnerability of MSM to HIV (Attipoe

2004). It was one of the first such studies in the sub-Saharan region, and it contributed to USAID's decision to include MSM in the design of a new bilateral HIV prevention and services program targeting most-at-risk populations (MARPs), along with female sex workers, their non-paying partners, and people living with HIV (PLHIV). Later that year, USAID funded AED to implement the five-year SHARP program.

The Attipoe study revealed that approximately half of the MSM surveyed also had sexual relationships with women, that about half were selling sex, and that nearly 80 percent would not go to a government health clinic if they thought they had an STI for fear of mistreatment, harassment, or arrest. These findings were all crucial to the subsequent design of SHARP's MSM-focused research and programming.

The program's early interventions were complemented by a research agenda designed to build an evidence base to validate the program's priorities, identify emerging challenges, and use insights gleaned from the research to design and refine effective interventions. SHARP's research focused on several populations considered at risk for HIV acquisition, including female sex workers, their clients and non-paying partners, MSM, long-distance truck drivers, and miners. This research served as the basis for setting a priority on programming for female sex workers (including outreach to their non-paying partners) and expanding interventions for MSM to reflect their disproportionate vulnerability to HIV. The data also provided valuable evidence for USAID and SHARP to gain buy-in from NACP for HIV prevention and other health services for MSM.

The first-year target for program enrollment of MSM was only 200, but there was concern that even this small number might be too ambitious. Although Attipoe's research confirmed the



James Robertson/ISI

CEPEHRG's drop-in center and clinic in Accra.

vulnerability of MSM in the country, there was no consensus on their numbers, and some authorities doubted that the program could find any more than a handful of them. Nonetheless, there was agreement that interventions should begin and that later they could be adapted and refined based on the information gained from SHARP's two research studies on MSM, which respectively examined the dynamics of MSM social networks and evaluated HIV prevalence and risk behaviors in this population.

SHARP began its work with MSM by reaching out to CEPEHRG, an organization founded to advocate for the human rights and health of young people and the marginalized. Led by a driven and passionate activist and with experience supporting sexual minorities, CEPEHRG was an important collaborator for SHARP as the program began developing its interventions for MSM. Trusted by community members, CEPEHRG facilitated entry into the MSM social networks essential for successful implementation of programming targeting this largely unseen population in Accra, Tema, and Koforidua. Meanwhile, SHARP provided funding and technical expertise necessary to

develop behavior change communication (BCC) resources, expand HIV/STI services, and support appropriate training and supervision for peer educators, CEPEHRG staff, and health care workers. Through this relationship, SHARP helped strengthen CEPEHRG as an institution and contributed to its evolution from a small CBO to a recognized nongovernmental organization (NGO) with an international reputation for work in advocacy and HIV prevention for MSM.

CEPEHRG's contribution to SHARP's work with MSM should not be underestimated. Known and trusted by MSM in Accra and other places around the country, CEPEHRG was able to leverage its social capital on behalf of SHARP. By offering access to MSM social networks that would otherwise have been difficult to identify and reach, CEPEHRG played a key role in developing and implementing the two MSM research studies that SHARP undertook. CEPEHRG's understanding of the challenges faced by MSM in Ghana directly informed the development of SHARP's outreach and prevention strategies for MSM, and the organization subsequently piloted those models, offering valuable feedback to SHARP to help refine and improve the interventions as they were scaled up.

SHARP's collaboration with CEPEHRG was essential to its successful development of intervention models responsive to the needs of Ghanaian MSM. To achieve the desired scale and geographic reach, the program identified additional implementing partners to support expansion of activities beyond Accra, CEPEHRG's primary base at that time. Given the sensitivity of the work, USAID authorized the project to sole-source these services without a standard competitive process. SHARP engaged three organizations that appeared to have applicable skills and the willingness to support HIV interventions for MSM: Maritime Life Precious Foundation (Maritime), Interfaith

Family Network (INFANET), and MICDAK Charity Foundation (MICDAK). For each organization, this was a new area of programming.

By the time SHARP closed in 2009, these four organizations had collectively reached more than 8,000 MSM with prevention messages and HIV-related services, exceeding targets in each year except the first. However, the organizations were not equally successful in these efforts. Both INFANET and MICDAK struggled to reach required performance targets, while CEPEHRG and Maritime were the strongest of SHARP’s four partners. Although the only organization of the four with a specific mission to work with sexual minorities, CEPEHRG started strong but faltered toward the end of the program as it tried to balance a broader organizational mission for advocacy on human rights with the demands of the HIV-specific activities supported by SHARP. Maritime, on the other hand, grew more effective and expanded its geographic reach and targets as it gained experience working with MSM.

Maritime’s mission and experience are different from CEPEHRG’s. Maritime was founded to address the needs of communities in the coastal

Western Region of Ghana, working with seamen, dock laborers, fishermen, and fishmongers. Prior to funding from SHARP, the organization had already carried out awareness programs on STIs, HIV and AIDS, malaria, and reproductive health issues with these groups, and had also supported orphans and vulnerable children, particularly those who had lost a parent at sea.

Program Offerings

Both CEPEHRG and Maritime have implemented a range of HIV- and STI-related services for MSM. While the relationship was sometimes troubled, working with SHARP allowed CEPEHRG to expand its program offerings and use its experience to contribute to the development of pioneering intervention models for MSM in the region. For Maritime, the activities implemented with SHARP’s support made it possible for the organization to develop capacity to work with MSM and gain increased sophistication with HIV-related programming in general. SHARP’s direct support to both organizations included performance-based funding, organizational capacity building, and technical support for prevention interventions, BCC resources, and service delivery.

Prevention outreach: Building on its research findings on MSM in Ghana, and in consultation with USAID and its government and NGO partners, SHARP worked with the Ghana Sustainable Change Project (GSCP)—another USAID-funded project implemented by AED—to develop a basic package of BCC tools and interventions for MSM, including a participatory training curriculum for peer educators (AED/ SHARP 2006b). The package also included a variety of job aids and communication materials for peer educators and health care workers, along with a cell phone-based information, referral, and counseling service: the “Text Me! Flash Me!”



James Robertson/JSI

Staff at Maritime’s drop-in center in Takoradi.

SUMMARY OF KEY BEHAVIORS FOR MSM PROMOTED BY SHARP

- Use condoms correctly during every sexual encounter.
- Use water-based lubricant together with condoms during anal sex.
- Get tested for STIs and HIV and know your status.
- Promptly seek appropriate treatment, care, and support for HIV and STIs.
- Disclose your HIV or STI status to partners.
- Adhere to HIV, STI, and TB treatment.
- Reduce the number of sexual partners.
- Actively participate in the HIV response.

Helpline. SHARP’s technical assistance and performance-based monitoring of each NGO partner’s program activities supported implementation of the package.

Peer educator-led outreach sessions for MSM promoted risk reduction behaviors (see the box to the left), offered referrals to testing and clinical services, sold condoms and lubricant, and provided counseling by trained health care workers in government and NGO-run clinics or through the Helpline service. By using an integrated approach, the program was able to disseminate consistent messages and correct information. Central to SHARP’s approach were well-trained and actively supported peer educators to encourage MSM to increase their health-seeking behavior and reduce their vulnerability to HIV.

The program also worked with its implementing partners on outreach events that included large community parties and small gatherings at private homes and at hot spots such as bars and clubs that attract MSM clientele. Integrating HIV prevention messages into social activities, these events raised awareness within a broader peer group of the value of open communication in MSM relationships and the importance of condom use and other prevention behaviors, such as partner reduction.

Mindful of the controversy that the term “men who have sex with men” might engender, SHARP used the more ambiguous “most-at-risk men” in the title and acknowledgements of the peer educator training manual, a central component of SHARP’s “It’s My Turn!” communication campaign for MSM. Although “MSM” is used consistently in the rest of the manual, the program recognized that by reducing the prominence of this term it might avoid unnecessary attention and criticism. As a way to discreetly mark the campaign as MSM-related, its graphics featured the rainbow, an international symbol of unity and pride among sexual minorities that is not well known in Ghana outside the MSM community.

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Courtesy of AED/SHARP and AED/GSCP

Pocket-size folded brochure on HIV prevention for MSM.

As noted above, the package included BCC materials that could be distributed to participants in prevention outreach sessions. The materials included pocket-sized brochures listing MSM-friendly clinics and drop-in centers or illustrating HIV and STI prevention behaviors. One of the brochures (see figure above) is purposefully graphic in its visual representation of behaviors that can reduce transmission risk of HIV and other STIs. The direct nature of these materials effectively reinforced the lessons taught during peer outreach, and the brochures proved to be valuable prevention tools.

HIV and STI services: Clinical services for MSM were also supported at government-run clinics as well as at the four drop-in centers run by SHARP’s NGO partners. Services included STI diagnosis and treatment, HIV counseling and testing, post-test counseling and support, antiretroviral therapy (ART), and referrals to other services if necessary. A total of 20 Ghana Health Service STI clinics and 18 ART clinics throughout the country received support. In the 2007–08

program year, 1,217 MSM received STI-related services at these facilities, and 972 were tested for HIV and received their results.

Health care worker training: To increase uptake of services, SHARP supported the training of health care workers—usually nurses—as a core strategy to develop health facilities friendly to MSM, female sex workers, and PLHIV. When members of these groups sought care in the past, they typically encountered health care workers who were either hostile or ignorant to their particular health needs. Working with WAPCAS, NACP, and the USAID-funded Quality Health Partners, a bilateral project implemented by EngenderHealth, SHARP developed a “MARP-friendly” curriculum and trained providers at 56 facilities to increase their understanding of MARP-related health issues and expand their capacity to provide responsive care in a supportive and non-stigmatizing environment.

Support groups: SHARP also encouraged its implementing partners to set up support groups for MSM living with HIV, although there was some

resistance to this idea due to concerns about confidentiality and fear of disclosure of HIV status. CEPEHRG and Maritime eventually established groups, including two in the Greater Accra Region with 26 and 18 members, respectively, and notably one in Elmina, a town on the Ghanaian coast with a population of only about 35,000 people, that had recruited 11 members.

“Text Me! Flash Me!” Helpline: Working with its implementing partners, including CEPEHRG and Maritime, SHARP made headway in developing services and engaging MSM in prevention outreach, but discovered that service uptake was less robust than desired. This prompted the program to consider new ways to reach this population. The idea of a telephone helpline was explored to allow MSM to contact the program for support but maintain their anonymity. Although not universal, cell phones have become the principal communication device for many Ghanaians, allowing both voice calls and text messaging. In Ghana, if people have charged phones and a minimal amount of call credit, they can receive calls and “flash” others. “Flashing” is calling and hanging up before the recipient of the call picks up. This costs nothing and signals that the caller at the number shown on the phone’s screen wants to be contacted. SHARP recognized the value of integrating these aspects of cell phone use into the design of this new initiative.

Branded as part of the “It’s My Turn” campaign, the “Text Me! Flash Me!” Helpline was staffed by employees of implementing partners and by HIV counselors from government clinics. To prepare them for this new role, SHARP worked with a number of stakeholders to develop a training curriculum (AED/SHARP 2009b) and provided ongoing support to the counselors after

the program was introduced. The Helpline was designed to function during a set period of time each day, and callers would “flash” the counselor on call, who could then phone back directly to answer questions, provide support, or share information about where to find services.

Users were also able to send text inquiries that generated automated text responses on a variety of basic topics relevant to MSM health and well-being. In turn, the callers’ cell numbers were recorded, with care taken to maintain confidentiality and protect their identities. Subsequently, these contacts were sent regular text message reminders about condom use, the need for testing, and the availability of the Helpline to answer questions or provide directions to clinics. The last of these examples is more important than it may seem. Consider Accra, Ghana’s large capital city of more than 1.5 million people. Its roads often lack signage, so landmarks are typically used to guide people to their destinations. With even government clinics tucked away in difficult-to-find places, someone seeking services could contact a Helpline counselor both for directions to an MSM-friendly clinic and for the encouragement sometimes needed to get the caller inside to actually access services.

The Helpline pilot was immediately successful (Clemmons 2009). In its first month, September 2008, the five initial counselors spoke with 439 MSM callers for an average of 20 minutes each. Callers responded positively to the friendly tone of the service and its confidentiality. Notably, demand soon outstripped the availability of counselors; nearly 1,000 flashes were missed because counselors were busy with other callers. By comparison, peer educators supported by the four SHARP partners implementing MSM

programming each engaged approximately 50 clients a month through traditional outreach; during the first month of the pilot alone, each Helpline counselor reached an average of almost 90 MSM. Even more important, after the launch of the Helpline, implementing partners saw noticeable upticks in demand for HIV counseling and testing and for a primary objective of the initiative, STI diagnosis and treatment services. After the Helpline was initiated, there was a sixfold increase in the number of MSM who received STI services at CEPEHRG's drop-in center. The results were so encouraging that SHARP developed a similar service for another of its target audiences, female sex workers.

What Worked Well

Ghana provides a richly instructive example of how to manage some of the challenges of implementing HIV programming for MSM in a socially hostile and politically unsupportive environment. While some of the difficulties are unique to the Ghanaian context, some basic elements of the approach used in Ghana can be adapted to other places where MSM remain underserved.

Formative research: Modern public health is built around evidence. Research and the data

After the Helpline was initiated, there was a sixfold increase in the number of MSM who received STI services at CEPEHRG's drop-in center.

it generates are some of the most valuable tools for identifying and responding appropriately to problems that affect the health of a population. As the global response to HIV has evolved, becoming more complex but also more responsive, evidence has become even more important, not only to determine action but also to evaluate impact. Indeed, if any reasonable progress is to be made in addressing the needs of sexual minorities in this epidemic, the need to develop an evidence base to guide the response is inarguable. Considering that the prospect of programming for MSM may generate resistance from some, as it did in Ghana, it is crucial to invest the time and energy to explain the need for action as a matter of public health. Formative research provides the evidence necessary to support that process. It can be done relatively rapidly, it generates data to argue for including MSM in programming, it helps determine the appropriate scale, it gives insight to more effectively reach this population, and it offers information necessary to develop the most appropriate services for MSM in the local context.

MSM organizations: In places where sex between men is highly stigmatized or illegal, it may be difficult, especially at first, to identify access points for reaching MSM. International advocacy and the movement of ideas through print media, and now even more rapidly through the Internet, have helped stimulate the emergence of a global rights movement for sexual minorities. Consequently, most large cities have groups that organize for the express purpose of supporting indigenous advocacy efforts. Fearful of exposure and reprisals, these organizations often maintain a low profile. They vary in degree of professionalism and potential as implementing partners, yet they are highly valuable resources already trusted by local MSM and able to identify and provide

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access to these networks. Care should be taken when engaging these groups to maintain their confidentiality and avoid friction with government authorities, particularly in countries that criminalize homosexual behavior.

Donor champions: Without clear policy guidance from the Government of Ghana on programming for MSM, the development of interventions for this population depended on the willingness of an outside donor—in this case, USAID—to take on the challenge. Balancing its development mandate with its diplomatic responsibilities, USAID gained buy-in for a bilateral program (SHARP) prioritizing MARPs and supported a research component within that program to confirm its priorities and identify any underserved or emerging concerns. This evidence-informed advocacy was essential to gain discreet acquiescence, if not actual vocal support, from GAC and NACP for MSM programming.

New technologies: Information and communication technology (ICT) offers a range of compelling opportunities to customize messages and target hard-to-reach MSM quickly and economically. SHARP used ICT innovatively in the development of the “Text Me! Flash Me!” Helpline to increase uptake of testing and other services among MSM. Often, ICT initiatives have sought to perfect a technology before rolling out a program.

Such an approach often requires investing time and money in the technological platform before fully understanding how end users will respond to the medium and how they will actually use it. SHARP worked within the existing functionality and limitations of the Ghanaian cell phone system. This allowed the program to focus on optimizing the end-user experience and properly training and supporting Helpline counselors. The pilot project demonstrated that the Helpline was effective in targeting a hard-to-reach population. SHARP used these findings to refine the model ahead of scaling up the intervention for MSM and expanding it to reach female sex workers and PLHIV as well.

Challenges

Legal and social vulnerability of MSM: MSM in Ghana are frequently subject to extortion and exposure, risking loss of jobs and families, and are often targets of verbal aggression, harassment, and physical violence. The agents of this dynamic are usually assumed to be outside the community of MSM, such as rogue police officers who seek bribes or sexual favors from MSM in exchange for leniency or freedom. However, informants have shared stories about MSM threatening exposure of their peers to gain advantage in a situation, typically concerning social position or a romantic entanglement. Threat of disclosure of HIV status was also reported, and this prospect was cited as the reason for CEPEHRG’s initial reluctance to develop support groups in Accra for MSM living with HIV. While this anxiety may have been reasonable, efforts to develop such support groups outside the capital city did not encounter this problem, nor have the two groups in the Greater Accra Region experienced any serious difficulties to date.

Confidentiality and new technology: Although ICT has great promise, capturing

identifying information on MSM without prior consent has risks, and program implementers should recognize that some individuals may not want to share their email addresses or cell phone numbers due to their quite legitimate fear of exposure. Both email and telephone contact information can be used to track or identify individuals. Significant efforts, therefore, should be made to assure users that their information is kept confidential and used for program purposes only.

Access to lubricant: SHARP leaders identified numerous difficulties in procuring lubricant to support condom use for anal sex among MSM. There were particular problems with the quality of available products, as well as with the lack of single-use packets that are easier to carry and thus more practical.

Competing organizational priorities: CEPEHRG's organizational mandate to advocate for the rights of sexual minorities alongside its work on health and HIV sometimes conflicted with the more focused programmatic priorities of SHARP. Program implementers should work actively with implementing partners, establishing clear responsibilities and expectations and building their capacity to support the specific demands of donor-funded initiatives. Well-functioning relationships between partners are a vital component of success, and it is important to find the right balance between an implementing partner's core mission and the demands of a donor-funded HIV program, particularly when it requires the partner to develop new capacity or significantly expand its activities in HIV.

Multiple implementing partners: MSM organizations can typically provide access to a portion of the population of men who have sex

with other men, but by no means to all of them. In Ghana, some MSM may be easily identified, drawn together by a need for social connection (at a bar or club), by a shared political agenda (in a rights group), or by economic necessity (in sex work). Some may be found in places where men seek out sex partners, but still others may not be so easily accessible. Consequently, as the SHARP experience with CEPEHRG and Maritime suggests, it can be valuable to work with a variety of organizations to develop programming for MSM. Identifying organizations willing to work on MSM issues is by no means easy, and their subsequent capacity to do this work successfully is not ensured. It may also be unreasonable to expect organizations that promote the rights of sexual minorities to take on the burden of protecting the health of these populations as well. The design of HIV prevention programming needs to incorporate the realities of human sexual behavior. To rephrase a slogan from the American gay rights movement: MSM are everywhere. Consequently, the institutional HIV response should aim to engage a variety of organizations to expand the number and type of interventions for MSM and increase the availability of MSM-friendly facilities and providers.

Knowledge gaps: Researchers often note that awareness about HIV does not always determine actual condom use. In discussions with MSM

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In discussions with MSM in Ghana, many said that before they received MSM-specific education, they had thought condom use was only necessary during vaginal sex.

in Ghana, many said that before they received MSM-specific education, they had thought condom use was only necessary during vaginal sex. Because most HIV prevention messaging in the sub-Saharan region aims to reach a general audience, it has tended to discuss sexual behavior in the broadest and most socially acceptable terms, relying on a heterosexual paradigm of risk. This narrow depiction gives people incomplete information and, as a consequence, some may engage in more risky sexual behavior thinking that they are, in fact, avoiding possible exposure to HIV. The relative absence of anal sex as a topic in general HIV prevention puts MSM at risk, as well as women who might consider anal sex an option to protect their virginity or avoid conception.

Recommendations

The pioneering efforts undertaken in Ghana provide useful guidance to inform the development of programming for MSM elsewhere. Interventions for MSM and other high-risk behavioral groups are appropriate in all epidemic types, including generalized ones, although local laws and social mores may present challenges to initiating these activities. For international donors, there may be legitimate diplomatic considerations

that should be addressed, and program planners should take into account relevant legal and cultural issues. Initially, progress may be slow due to lack of expertise or experience in this area; however, local MSM and community organizations can provide the initial insights and spark necessary to start and sustain successful programs.

Leverage MSM community knowledge: Community-based organizations, informal social groups, and even individuals may provide the most important information and resources available to programmers considering where and how to begin working with MSM, by providing access to members of this population, insights into the challenges they face, and guidance on how best to address their needs (AED/SHARP 2009a).

Undertake formative research: Evidence is a fundamental tool in modern public health, and while politicians may be unwilling to support programming for MSM, technical leaders can often be convinced. An evidence base is critical to the development of MSM interventions, serving to make the case for action and providing information to increase effectiveness of programming (AED/SHARP 2009a).

Pilot interventions: In an unsupportive environment, small-scale pilot programs can be implemented quickly and confirm demand for services, show efficacy, and provide more evidence to convince skeptics. Pilot programs also provide important lessons to strengthen and improve later interventions.

Find an appropriate balance with rights advocacy: International best practice identifies efforts to improve the rights of MSM and other sexual minorities as central to an effective

HIV response for this population (UNAIDS 2009). Program implementers should carefully balance advocacy with the development of effective interventions for MSM (AED/SHARP 2009a).

Increase resource investment in HIV programming for MSM: Until MSM-friendly services are available, most MSM are unlikely to demand them. Programs need to be funded and expanded to build direct services for MSM and strengthen government systems to better respond to the needs of MSM and other sexual minorities.

Use social networks to reach MSM: Direct social support, along with the sense of community created by personal contact with peer educators and new technologies such as text messaging, helps empower MSM and build self-esteem, in turn contributing to decreased risk-taking behavior. Social networks can also be valuable entry points into sexual networks that may be more difficult for programs to access (AED/SHARP 2009a).

Engage multiple partners to implement programming for MSM: Relying on a single organizational partner can be risky. Dividing the responsibility among multiple partners increases the number of organizations engaged in addressing the HIV and health needs of MSM. A larger variety of MSM are likely to be reached by using a range of organizations with different profiles and missions.

Link MSM clients to government health facilities with health care workers trained to provide MSM-friendly services: Health care providers remain key allies in efforts to improve the health and HIV

situation of MSM. Building their capacity to provide responsive services for MSM increases uptake, improves quality, and helps raise awareness of the needs of this population (AED/SHARP 2009a).

Remain sensitive to social hostility and the criminalized status of MSM: As this case study suggests, the marginalization of MSM creates significant barriers for program implementers. Social hostility and legal censure limit the options of MSM, increasing their vulnerability and discouraging their engagement with services such as those offered by CEPEHRG and Maritime. Programs should not lose sight of the difficult context in which MSM clients live and should work to address these challenges in the design and execution of interventions.

Future Programming

Even using conservative estimates, MSM in Ghana remain underserved. Activities need to be expanded to reach the scale required to serve a larger proportion of this population. At current levels, coverage is inadequate. International organizations and donors will continue to have valuable contributions to make to these efforts.

Community-based organizations for MSM such as CEPEHRG are essential partners in efforts to access MSM and stimulate uptake of HIV services, providing experience and insight that may not be available outside this community. However, these organizations present challenges for donor agencies and governments that may not share similar priorities or interest in promoting a rights-based agenda. Of course, no single organization in a country can be expected to address the HIV-related needs of a population as diverse as MSM.

Strengthening a variety of CBOs and NGOs, both those that focus on MSM and others that work more broadly on HIV and health, is potentially a more effective way to reach larger numbers of MSM. Developing an array of service options is likely to have the greatest impact. Building the capacity of organizations such as Maritime that are inexperienced but willing to take on the challenge of supporting MSM-focused HIV prevention interventions expands geographic reach, helps normalize same-sex sexuality in the wider community, and establishes a greater range of outlets and providers offering services to MSM.

Government health systems need to encourage and support HIV and health programming for MSM and other sexual minorities; at the very least, they should not be obstacles. The progress made in Ghana was facilitated by both quantitative and qualitative research on MSM in the country. Research questions about sexual orientation and specific sexual behaviors should be added to all routine national demographic surveys and other data collection instruments, and these data should be used to guide programmatic priorities and resource allocation decisions. Ongoing training

The vulnerability of MSM to HIV needs to be acknowledged as an urgent priority, in Ghana and elsewhere, by a range of stakeholders with the capacity to effect change, including governments, donors, and civil society.

of health care workers to provide supportive and responsive care to MSM and other sexual minorities will further help address the stigma and discrimination experienced by many MSM seeking care.

Decriminalization of same-sex sexual behavior should remain a goal. Legal constraints notwithstanding, the vulnerability of MSM to HIV needs to be acknowledged as an urgent priority, in Ghana and elsewhere, by a range of stakeholders with the capacity to effect change, including governments, donors, and civil society. □

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RESOURCES

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AED/SHARP

www.aed.org/Projects/ghana-sharp.cfm

USAID/Ghana

www.usaid.gov/gh

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