SOUTH TO SOUTH LEARNING NETWORK

The HIV Prevention Interchange

A comprehensive approach to reaching MSM online in resource-limited settings: How to utilize existing Information and Communications Technology platforms to generate demands for services

A Case Study from Kenya

BRIEF OVERVIEW OF KENYA'S HIV CONTEXT

Kenya, jointly with Mozambique and Uganda, has the third-largest HIV epidemic in the world. Kenya's HIV epidemic is driven by sexual transmission and is generalized, meaning that it affects all sections of the population including children, young people, adults, women and men. Based on the Kenya Population-based HIV Impact Assessment preliminary report (KENPHIA, 2018), the prevalence of HIV among adults in Kenya was 4.9% in 2018. This translates to approximately 1.3 million adults living with HIV in Kenya. HIV prevalence was twice as high among women at 6.6% compared to men at 3.1%. HIV prevalence among children was 0.7% which translates to approximately 139,000 children living with HIV in Kenya.

In recent decades, **Kenya has been a huge prevention success story in the region**. Kenya was one of the first countries to scale up voluntary medical male circumcision (VMMC) and programs for key populations. They were also one of the first African counties to approve the use and scale up of PrEP. Kenya has continued to see a decline in HIV incidence among adults aged 15-49 from 3.2% in 2013 to 1.2% in 2019 (HIV estimates 2020, NACC).

OVERVIEW OF KENYA'S KEY POPULATION EPIDEMIC AND RESPONSE

Key populations in Kenya contribute approximately **one third of all new HIV infections** in the country (MOT, 2009). Prevalence among key population groups is disproportionately higher than the general population, ranging from 29.3% among female sex workers (FSW), to 18.2% among men who have sex with men (MSM) and 18.3% among people who inject drugs (PWID). A recent national mapping and population size estimation exercise estimated 167,940 [129,271-206,609] FSW, 40,725 [30,880-50,569] MSM, 16,063 [12,426-19,691] PWID and 4,305 [2,826-5,783] transgender people in Kenya (KPSE 1 report, NASCOP 2019).

The National AIDS and STI Control Programme (NASCOP) and the National AIDS Control Council (NACC) within the Ministry of Health, lead the KP program in Kenya. The program aims to reach a high proportion of key populations and ensure that they have access to a combination of targeted behavioral, biomedical, and structural interventions. The KP program has been scaled up in Kenya with funding support from PEPFAR, the Global Fund and the Government of Kenya. Currently, **the KP program in Kenya reaches over 90% of estimated FSW, MSM and PWID**; however, the current program for transgender people is still sub-optimal and further efforts are being made in the country to scale it up.

PROGRAM INNOVATION

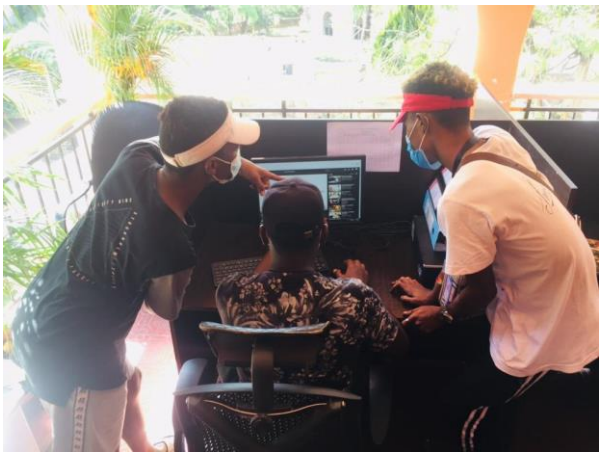
MSM community consultations highlighted the fact that there was **a growing population of MSM who sought male sexual partners through virtual sites and information and communications technology (ICT) platforms**. These men were not being reached by the existing HIV program which uses a physical *hotspot* based

approach to outreach, for example, peer educators go to Mios and Pirates Bar for outreach, among others. Closure of these physical hotspots due to COVID-19 pandemic amplified the transition of MSM onto virtual sites, and ICT platforms mushroomed.

NASCOP and the University of Manitoba (UoM) in partnership with MSM-led community-based organizations (CBOs) conducted a mapping and size estimation of MSM in virtual sites in selected counties. Internet applications, dating and social networking sites, local Facebook and WhatsApp groups were mapped during the study, where MSM respondents were found on average to have profiles on 2-4 of these sites. The majority of the users were below 25 years and had connected with around 17 other men in the last week. It was also noted that 26% of MSM who sought sexual partnerships in virtual sites did not visit physical sites [Emmanuel F et al. 2020]. In another recent study, it was found that HIV prevalence among MSM who engaged in only virtual sites (26.7%), was higher compared to those who engaged in both virtual and physical sites (15.4%) or physical sites only (8.5%) (Bhattacharjee P et al, 2020). Based on this evidence, the national program decided to **pilot and scale-up interventions with MSM who seek sexual partners in virtual sites**.

Several MSM-led organizations and other civil society organizations have now initiated interventions in virtual sites with MSM. This case study focuses on one such intervention implemented by HAPA Kenya, an MSM-led organization implementing HIV prevention programs with MSM in Mombasa county.

The below focuses on how HAPA Kenya used existing ICT platforms to (a) provide information, (b) generate demand for services and (c) link the MSM who engaged in these sites/ platforms with prevention, testing and treatment services.



Virtual Peer Educators following up on clients using online platforms

KEY ACTIVITIES

HAPA Kenya **first identified MSM peer educators within the organization**, who used virtual sites to seek male sexual partners. In consultation with the peer educators and other MSM members, HAPA Kenya then **mapped out the virtual sites used by MSM networks** in Mombasa. Team members accessed each site at multiple times in the day to assess the popularity of the site and estimate the number of MSM actively using them. This helped to identify the **most popular sites to plan the interventions**.

HAPA Kenya then **recruited virtual peer educators (VPEs) who were active on the selected virtual sites**. The criteria for selecting these peer educators were: a high level of engagement on the virtual sites; a high number of followers/ contacts on these sites; an interest in working with the MSM community on HIV prevention, innovative ideas and diverse site presence. A supervisory position was also created to support the virtual peer educators (VPE).

A **2-day initial training was conducted for the VPEs by NASCOP**. In addition to technical content training, special emphasis was placed on training the VPEs on their own security and professional conduct during virtual outreach. Monthly meetings and debriefs with VPEs as well as refresher training are part of the standard operating procedure for the initiative.

The trained VPEs were allocated specific virtual sites based on their comfort and familiarity. VPEs were offered the opportunity of creating catchy IDs on the sites they were responsible for, however many of them used their names to leverage on their 'following'. The VPEs logged into the allocated virtual sites every day at different times to make contacts. The VPEs introduced themselves to the new contacts and shared the services provided by HAPA Kenya. Social and casual chats were done with MSM on those sites who were known or had been contacted before. **Information related to health, HIV services and various events organized by HAPA Kenya were shared through virtual posters and videos.** The conversation always ended with **a call to action and in this case, it was to visit the HAPA Kenya clinics** (including outreach clinics) and drop-in centers for services and support.

During initial contact, the VPEs gathered information on the preference of the peer for services. Various options were provided such as **MSM friendly drop-in centers, outreach clinics in safe spaces or identified government clinics**. HAPA Kenya also provided the option of receiving commodities and self-test kits at the client's doorstep. After the peer receives services, the VPE follows up with the peer within 14 days to get feedback and remind them of various services offered by the organization.

Each VPE was given a notebook to note the following: name of peer, telephone number/ contact, age, etc. After building rapport with the MSM client, the VPE had to take consent and fill a contact form for each MSM client (similar to what is done in the physical site). Regularly, the VPE has to fill a peer calendar to track the services provided to the virtual MSM client. **All virtual MSM peers are encouraged to visit the clinic and enroll in the clinic as that helps in putting a face to the name**.

KEY ACHIEVEMENTS (AUGUST 2019 – JULY 2020)

1. Number of MSM contacted by virtual peer educators in the virtual sites: **1439**
2. Number of MSM from virtual sites registered in the project: **205**
3. Number of MSM from virtual sites who are enrolled in the clinic: **183**
4. Number of MSM from virtual sites who regularly receive services every month: **205**

OPPORTUNITIES FOR DEVELOPMENT

1. This innovation has allowed the organization to contact MSM who seek sexual partners in the virtual site. These MSM were not reached by the organization and the program before. The challenge has been to convert the contacts to registration into the program as only 15% of those contacted agreed to register in the program. Registration into the program allows regular contact with the program and follow up.
2. Outreach through virtual sites has effectively reached MSM in urban and semi-urban areas where access to the internet is high. This may not be an effective strategy to reach rural MSM. Currently, the rural-based MSM are best reached through physical peer to peer approach. Another challenge has been reaching older bisexual men through this process as they prefer to use more private premium packages in the sites.
3. After the virtual outreach, the VPE encourages the peer to visit the clinic. A visit and enrollment in the clinic offer a face to face interaction and identification of the person who is just a name in the virtual interaction. This also helps in reducing duplication in registration as MSMs using virtual sites visit multiple sites with multiple ID and can be met by different VPE and registered as different people. However, follow-up after a virtual conversation sometimes is a challenge as peers block the VPE's number after receiving information.
4. Follow-up of the intervention needs to accept and respect that some MSM may want their privacy. The intervention has to sometimes deliver commodities and services to MSM in virtual spaces at places convenient to the peers. This can sometimes cause safety concerns for persons delivering these commodities.

COST CONSIDERATIONS

1. Cost of honorarium of virtual PE and salary for a supervisor ($50 per VPE per month, $120-150 per supervisor per month). In Kenya, in an MSM program, the peer educator to peer ratio is 1:30

2. Tablets or computers as well as internet costs for the virtual outreach team ($3000 once-off)
3. Training and capacity building ($400 per training). There may be 2 training sessions in a year
4. A membership fee for internet apps ($200 annual subscription for the virtual sites in which the organization have selected)
5. Cost of delivery of services in a safe place (in case the place is not a normal hotspot) ($20/ month/VPE)

KEY LESSONS

1. Reaching MSM via virtual sites ensures that we **engage those who do not access physical hotspots, or are unaware that MSM friendly HIV safe spaces and clinics exist**. This innovation facilitates reaching those who are at risk but are left out of the program.
2. **Consultation with the MSM** who seek sexual partners using virtual sites is critical in the design and implementation of an intervention reaching them.
3. Considering same-sex relationships are criminalized in many countries, **policy guidance to work with virtual MSM or MSM in general, from the national KP program or Ministry of Health is critical**.
4. **Safety of the VPE should be ensured** as they are prone to blackmail, harassment and violence sometimes.
5. Regular engagement with the MSM who use virtual sites with **new messages is important to keep them interested** and hooked to the intervention.
6. A **variety of options for service provision need to be provided** to the MSM who engage on virtual sites. The MSM clients may choose to stay invisible and that has to be respected.
7. It is **not very expensive** as the innovation used existing ICT platforms rather than developing a new one.

"This is the greatest innovation in MSM programming. Due to the shift of MSM clients to online platforms, the government, MSM programs, donors have to initiate interventions in these spaces to ensure that no one is left behind".

Oliver Muindi
Social Worker, Kenya
HAPA Kenya

"Our strategies have to keep up with the emerging needs and context of KP. In partnership with the implementing partners, the KP programme continuously strives to explore unreached spaces to expand programme reach".

Helgar Musyoki
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