International HIV/AIDS Alliance

Together to end AIDS

Case Study

Service Delivery Outreach Models for MSM

Experiences from Kenya and Uganda

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About the International HIV/AIDS Alliance

This case study has been developed within the framework of the Sexual Health and Rights Programme (SHARP) in Africa. SHARP is a three-year programme (1 December 2012 to 30 November 2015) funded by the Danish International Development Cooperation (DANIDA). The programme supports the International HIV/AIDS Alliance's 2013-2020 strategy HIV, health & rights: sustaining community action. Within this strategic framework, SHARP is contributing to increasing the reach of key populations through a targeted response to reach and empower men who have sex with men and link them to sustainable, quality health and social services.

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Cover image:

Happy to receive negative results, HIV finger prick test, MSM forum and outreach at Kisumu District hospital, run by MAAYGO, Kisumu, Kenya

Context

Engaging in same-sex sexual intercourse in Kenya and Uganda is a risky business, forbidden by law.[1,2] In both countries the experiences of gay and bisexual men and other men who have sex with men (MSM) often equate to stories of exclusion, isolation and, at times, abuse and violence. It takes courage to be 'out and proud' in East Africa. It takes even more courage to demand social recognition and advocate for human rights – and yet it's happening. Human rights activism in both countries is not just alive but rapidly developing, sustained by a wealth of lesbian, gay, bisexual, transgender and intersex (LGBTI) organisations that work tirelessly to advocate for change and meet the needs of increasingly visible LGBTI communities.

Addressing the specific sexual health needs of MSM is critical to realising their rights, both as individuals and members of society

Addressing the specific sexual health needs of MSM is critical to realising their rights, both as individuals and members of society. This is especially needed in Kenya and Uganda where HIV prevalence among the general population is particularly high at around 5.3% in Kenya[3] and 7.3% in Uganda[4]. Due to the repressive social environment, little official data has been gathered on MSMs' HIV knowledge and behaviours. However, studies suggest that MSM face a higher risk of HIV infection in these countries. Estimates of prevalence rates among MSM range from 12.3% to 43%[5,6,7] in Kenya and 13.7% in Uganda[9], and HIV knowledge among MSM in both countries, albeit improving, remains low.[10]

In addition, resources and services that meet the specific needs of MSM, their sexual partners and family members, are very limited in both countries and access is hindered by heightened stigma and discriminatory laws and practices – including in clinical health settings.

Why do we need MSM-tailored sexual health services?

The phrase 'men who have sex with men' describes same-sex behaviours between men. It is often equated with a homogenous group of gay men, but actually represents varied identities, sexual orientations and particular cultural categories. MSM possess differing socio-economic backgrounds, values, beliefs, cultures, religions and lifestyles. Some identify as gay, some are male sex workers who identify as heterosexual; some are married to women, others

1 Penal Code of Kenya, Revised Edition 2012 [2010], section 162
2 The Uganda Penal Code Act of 1950 (Chapter 120) (as amended) 166 Section 145. Unnatural offences.
3 Kimanga, Do et al., Prevalence and incidence of HIV infection, trends, and risk factors among persons aged 15-64 years in Kenya: results from a nationally representative study, J. Acquir. Immune Defic. Syndr., online edition.
4 The Uganda National HIV AIDS Strategic Plan 2015/2016 - 2019/2020, Uganda Aids Commission, April 2015.
5 Singh, K., et al., A venue-based approach to reaching MSM, IDUs and the general population with VCT: a three study site in Kenya. AIDS Behav, 2012. 16(4): p. 818-28.
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9 Hladik, W., et al., HIV infection among men who have sex with men in Kampala, Uganda--a respondent driven sampling survey. PLoS One, 2012. 7(5): p. e38143
10 Geibel s., Same-sex sexual behavior of men in Kenya: Implications for HIV prevention, programs, and policy, Facts Views Vis Obgyn. 2012; 4(4): 285–294.

are single and have sex with both men and women. The identities are diverse; the common characteristic is that of sexual behaviour.

Research tells us that people share common health needs, regardless of gender or sexual orientation. However, when compared to the general adult population, globally MSM are more likely to acquire HIV and STIs.[11] Many factors contribute to the vulnerability of MSM and the disproportionate burden of HIV and sexually transmitted infections (STIs) they experience. For instance, unprotected receptive anal intercourse; a high number of male partners; sexual violence; and the use of recreational substances such as alcohol and drugs are all behaviours associated with higher HIV incidence rates. In addition, laws and policies that criminalise MSM, social discrimination, homophobia, rejection and marginalisation can lead to depression and other mental health issues that impact people's ability to protect themselves from HIV and STIs. It can also lead to increased risk-taking behaviours such as alcohol, drugs and other substance abuse and unprotected sexual intercourse.[12,13]

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To reduce MSM's vulnerability in relation to HIV and STIs, sexual health services need to be tailored to their unique healthcare needs. However, in Kenya and Uganda such services are rare or insufficiently distributed, and the availability of health professionals who are competent in working with MSM is sparse. Moreover, discriminatory practices displayed by many healthcare providers prevent MSM from accessing healthcare. Judgemental behaviour and a lack of understanding shown by healthcare professionals, coupled with a perception that health services mostly cater for heterosexual people, results in many MSM being unwilling to seek health services.[14]

In order to receive appropriate care, MSM need to be able to disclose their sexual behaviour and share their personal history with healthcare providers but, due to the fear of stigma and rejection, many do not. Both perceived and experienced stigma in healthcare settings leads many MSM to delay seeking care; failing to continue in care or opting to self-medicate.

Safe and engaging environments in health clinics, and the presence of healthcare workers capable of delivering ethical, person-centred care in an open and unassuming manner, promote disclosure and can result in MSM accessing, and retaining, healthcare.

In Kenya and Uganda, stigma-free MSM-competent clinical environments are only just starting to exist but they remain scarce and are not always known to the local MSM groups. To reach as many MSM as possible with appropriate sexual healthcare, services need to be provided outside of traditional healthcare settings,

[11] Beyrer, C., The Global HIV Epidemics among Men Who Have Sex With Men: Epidemiology, Prevention, Access to Care and Human Rights, World Bank Publications, 2011
[12] Mayer, K.,H., et al., Comprehensive clinical care for men who have sex with men: an integrated approach, the Lancet, 2012, 380:378-87
[13] Global Forum on MSM & HIV, Social discrimination against men who have sex with men: Implications for policy and programs. 2010
[14] Ayala, G., et al., Engaging with Men who have Sex with Men in the Clinical Setting: a primer for physicians, nurses and other health care providers, Global Forum on MSM & HIV, 2011.

in places where MSM meet and socialise without the fear of being rejected or badly treated. In both countries a few community, national and international organisations are setting up outreach activities tailored to the needs of MSM, in some cases in collaboration with government clinics. However, a lack of information about MSM (e.g. population size and location), coupled with a lack of political will from decision makers and a lack of specific MSM funding, prevents the implementation of traditional outreach strategies and requires innovation. Moreover, in hostile environments outreach activities for MSM need to take place in ways that do not attract too much attention, at times in complete secret.

The project

To respond to this, the International HIV/AIDS Alliance implemented a programme aimed at effectively reducing the spread and impact of HIV among MSM, while building healthy communities of MSM in East Africa. The programme, known as SHARP (Sexual Health and Rights Programme) operated between 2012 and 2015 in Kenya, Uganda, Tanzania and Zimbabwe. Taking a multi-tier approach, it focused on both individuals and communities, integrating clinical service provision tailored to the specific needs of MSM, with structural level interventions targeting policy makers and wider communities. MSM-led community based organisations (CBOs) were the main implementers in each country. This strengthened MSM organisations and networks in the region, fostering meaningful engagement and ownership.

This case study focuses on two such organisations: Men Against AIDS Youth Organisation (MAAYGO) in Kisumu, Kenya and Ice Breakers Uganda (IBU) in Kampala, Uganda. It examines the different outreach models implemented by each organisation to improve access to sexual health services for MSM in contexts where homosexuality is not only socially unacceptable - it is also criminalised.

Men Against Aids Youth Group (MAAYGO) is an independent community based organisation. Its members are MSM affected by HIV and AIDS aged between 18 and 35 who self-identify as gay, bisexual, male sex workers and transgender. The group started meeting informally in an effort to know more about HIV and safer sexual practices, then registered with the Ministry of Gender, Children and Social Development in 2008. Since then, MAAYGO has advocated for equitable access to effective HIV prevention, care treatment and support services for the MSM community of Kisumu district in Kenya.

Ice Breakers Uganda (IBU) is a community based organisation that supports people who are LGBTI and raises awareness about sexual health and risky sexual behaviours, with a particular emphasis on HIV, AIDS and STIs. IBU advocates for, and promotes, respect for the fundamental rights of LGBTI people in Uganda. The organisation started as an informal support group for MSM in 2004. IBU registered under the Companies Act in 2012.

The service delivery outreach models

The service delivery outreach strategy adopted by the two organisations to engage MSM uses two complementary models:

1. Outreach conducted in community drop-in centres within the CBO's premises
2. Mobile clinical outreach conducted both during the day and at night at pre-arranged locations (e.g. bars and hotels) or at MSM 'hotspots'[15]

What do we mean by outreach?

The set of health services provided to MSM outside traditional clinical settings. This includes mobile clinics and community drop-in centres.

Each approach provides a basic package of sexual health services and were implemented, with some differences, by both MAAYGO and IBU. The service package was designed in line with World Health Organisation (WHO) guidelines on key populations and included most of the recommended services for MSM.

Table 1 lists the elements of the package provided by the two organisations and shows which model was used to deliver them:

Minimum package of services[16]	Drop in centre		Mobile Outreach	
	IBU	MAAYGO	IBU	MAAYGO
Provision of condoms and condom-compatible lubricants	✓	✓	✓	✓
HIV testing and counselling	✓		✓	✓
Referral for antiretroviral treatment (ART)	✓		✓	✓
STI testing, diagnosis and treatment	✓		✓	✓
Behaviour Change Communication (BCC) through peer-driven educational activities (done individually and in small groups)	✓	✓	✓	✓
HIV and sexual and reproductive health and rights (SRHR) counselling (done individually and in small groups)	✓	✓	✓	✓
BCC through the provision of HIV/SRHR information, education and communication (IEC) materials	✓	✓	✓	✓

Community drop-in centres

Outreach activities in community drop-in centres have typically taken place within the premises of IBU in Kampala and of MAAYGO in Kisumu. Through peer educator referrals, word-of-mouth and social media, MSM were informed about the centres and invited to attend during opening hours to make use of the services on offer.

At the IBU drop-in centre in Kampala, clinical services were provided through a partnership with the Most at Risk Population Initiative (MARPI), an organisation

[15] Specific geographic location where MSM gather or congregate

[16] Note that the SHARP Minimum Service Package also includes services such as PEP, harm reduction, legal services and crisis response. These were not included in the table as these were services not offered by MAAYGO or IBU

based in Mulago Hospital that specialises in providing sexual and reproductive health services for key populations. MARPI doctors provided tailored MSM services at the IBU drop-in centre twice-a-week. IBU staff and peer educators complemented the package with the provision of behaviour change communication (BCC) services such as health education talks and counselling.

In Kisumu, services available at the MAAYGO drop-in centre were limited to the non-clinical elements of the minimum service package and were directly provided by MAAYGO staff and peer educators. When clinical services were required that were not available at the drop-in centres, or when cases were complex and required special attention, both organisations established safe referral pathways to MSM-friendly, state-run clinics or other organisations providing HIV and reproductive health services. Services referred normally included HIV counselling or testing, STI screening and treatment and ART medication.

Both CBOs invested significant time and effort in mapping, vetting and monitoring the services to which MSM were to be referred. For MAAYGO, this meant developing strategies to engage sexual health providers such as the Kisumu County Hospital and the Regional Hospital. After personally introducing their organisation to the Kisumu County Health Director, MAAYGO staff became increasingly involved in the hospital's health education activities. Eventually, this involvement enabled MAAYGO to obtain a space within the hospital to deliver weekly HIV and STI prevention education sessions for MSM.

Another critical component in the creation of safe referral pathways was the training of healthcare workers in the STI and HIV departments. This increased staff's understanding of the vulnerabilities and specific health needs of MSM. The training courses, implemented in collaboration with the SHARP project team and ANOVA's Health4Men initiative, were also offered to mobile clinic staff in order to reach MSM in resource-constrained settings with prejudice-free services that were both medically and culturally competent.

The training activities have established strong ties between the two CBOs and the public health providers, creating relationships of reciprocal trust that have contributed to the intervention's sustainability.

To monitor the system, referrals were tracked through paper-based forms and verified for completion at the receiving clinic at the end of each month (for every referral, a form was kept by the drop-in centre and another handed in at the receiving clinic). In addition, both as a way to provide extra support and to ensure referrals were attended, IBU and MAAYGO staff offered to accompany clients to clinics, where possible on the same day as the referral was made, or on the first available day.

Another critical component in the creation of safe referral pathways was the training of healthcare workers in the STI and HIV departments.

Mobile clinics

The second strategy employed both by MAAYGO and IBU was based on the use of mobile clinics. Essentially, a mobile clinic enables clinical services to be provided in places where they are not usually available, albeit for a limited time. Such a model widens access for MSM who could not, or would not, access sexual healthcare in more traditional clinical settings. To ensure safety and confidentiality, both organisations carefully mapped and selected mobile clinic locations. In safer neighbourhoods, mobile outreach was organised in the premises of, or just outside, particularly tolerant hotels and bars. In more dangerous contexts, mobile clinics were set up in secret locations or innovative approaches adopted, as was the case with IBU described below.

In Kenya, MAAYGO conducted mobile outreach in Kisumu town and in six neighbouring districts through a partnership with the Kisumu County Hospital. A team of MAAYGO and hospital staff set up tents in locations such as nightclubs, hotels and bars known to be frequented by MSM, and offered services such as HIV testing and counselling (HTC) and STI screening. To ensure participation, MSM were mobilised by MAAYGO peer educators through their own networks both in advance, and during the outreach. Similar to the drop-in centre model, social media such as Facebook and WhatsApp and new mobile technologies enabled peer educators to reach and mobilise large numbers of MSM.

To maximise attendance, mobile outreach occurred during the week and over the weekend, both day and night (the night clinics became known as ‘moonlight clinics’). Thanks to its partnership with Kisumu County Hospital, MAAYGO has been able to expand its reach. It has successfully involved state-run health providers from other districts in mobile outreach to benefit local MSM groups identified by MAAYGO through its peer educators’ networks.

Similarly, the mobile outreach model implemented by IBU took advantage of its strong partnership with MARPI and the clinical services it provides. Mobile clinic outreach has been conducted in the capital Kampala and in 13 other major cities. The model adopted by IBU in Kampala is similar to the one used by MAAYGO in Kisumu, with outreach conducted in pre-identified ‘hotspots’ and mobilisation conducted through peer educators’ personal networks. However, the model in the rest of the country is best described as a decentralised one which operated through ‘cells’ that formed spontaneously as a result of informal personal contact between IBU staff and individuals from local MSM groups. In some cases, these cells have developed into more formal groups that are now constituted as CBOs in their own right.

This decentralised model was implemented on a rolling monthly basis, with MARPI staff providing clinical services and IBU staff running peer-driven BCC activities and general outreach management. MSM were mobilised through word-of-mouth and social media. Since it was not always possible to identify

spaces where mobile outreach could be conducted in a safe environment, IBU adopted innovative strategies to provide services to MSM. Notably, one such approach saw mobile clinics established in public and easily accessible spaces such as markets or main streets. In order to remain inconspicuous, the mobile clinic offered both men and women rapid HIV testing. However, only MSM clients could access the full range of HIV and STI services. In order to be identified as such, clients provided a special password, given to them in advance by a peer educator. The full range of services provided by MAAYGO and IBU during mobile outreach can be seen in Table 1.

IBU and MAAYGO's experiences demonstrate how providing services tailored to meet the needs of MSM in contexts where homosexuality is criminalised and socially disapproved of requires significant investment in time and resources, both human and financial, to mitigate and, where possible, influence the external environment. Preparatory work not only included mapping 'hotspots' and identifying safe locations; when and where possible it also meant engaging local communities such as those surrounding a drop-in centre, as well as trying to sensitise religious and other local leaders on MSM health needs to ensure outreach could be carried out safely for both clients and the CBO staff.

Despite these efforts, some negative reactions to the project still occurred. For instance, MAAYGO's offices were raided and a number of staff arrested for 'illegally promoting homosexuality'. However, MAAYGO turned this into an opportunity and embarked on a long process of engaging local chiefs and various branches of the local government, including the local police department, to sensitise them on MSM health needs and their right to access services. This process not only created more acceptance in the local community for MAAYGO and its activities, but prompted the police to provide protection in the form of two plain-clothes police officers who attended mobile outreach activities.

Rainbow flag hanging at MAAYGO offices, Kisumu, Kenya © Corrie Wingate

Critical elements of both outreach models

The process of setting up these services has been iterative and a learning journey for both organisations. Despite their different contexts and experiences, a number of critical elements will be relevant to others attempting a similar approach.

Services by MSM for MSM: This is the most important element of both outreach models. In contexts where being identified as MSM can mean being arrested, a model that offers basic packages of HIV and sexual health services for MSM must be one that an MSM can trust. Empowering MSM-led organisations is a key feature of the model as MSM cannot and should not simply be recipients of care but agents of care: meaningfully involved in identifying, reaching, linking and ensuring other MSM can access and take up services. Ultimately, involving communities in the delivery of services to communities translates into ownership and empowerment. In this sense, MSM organisations that provide services for MSM have a distinct advantage, as they are trusted in a way that can't be replicated by organisations that are not part of the MSM community.

Peer educators: Within a framework of services-by-MSM-for-MSM, peer education becomes a critical element as the MSM peer is the first recipient of the MSM client's trust. In such a model, the peer educator network is vital to improving access to services, and the rapidity by which a network grows and expands becomes a measure of the peer educators' success in mobilising people. Outreach targeting MSM is successful when peer educators are 'on the ground', physically moving around town to promote outreach in bars, clubs and other venues as well as reaching people through social media.

Sensitising healthcare workers: For the outreach model to be successful, the trust that a client grants to an MSM organisation needs to be extended to the clinicians involved in the provision of care. For this to happen, and in order to confidently refer MSM to the health clinics, both organisations successfully engaged healthcare workers in a series of training sessions to increase their understanding of the specific needs of MSM. In this sense, the training sessions were critical in ensuring both the provision of safe and non-discriminatory services as well as the intervention's sustainability. As confirmed by the participants themselves, the training activities, conducted both by CBO staff and in partnership with the Health4Men Initiative, have helped expand the health workers' knowledge of gender and sexuality, providing them with new skills on how to assist MSM clients accessing clinics.

> "At the beginning it was difficult for MSM to come to the hospital. Now MSM in the community know that we have been sensitised, trained and they don't fear us"
>
> ***A healthcare worker in Kisumu***

Establishing partnerships: Both organisations were able to develop successful formal and informal partnerships with public clinics and other large providers of sexual health services (such as Liverpool Voluntary Counselling and Testing in Kisumu and the Aids Support Organisation in Uganda). Partnerships between CBOs and clinical service providers are mutually beneficial. Clinical providers gain access to groups of MSM that they wouldn't have known how to reach before, while the CBOs are able to provide MSM with clinical services and extend the geographical reach of their own services as a result of community health system collaboration. These partnerships also help make the models more sustainable as they provide scope to deliver comprehensive care packages through role sharing. In Uganda, the partnership with MARPI, which is in turn supported by the Ministry of Health, gave IBU some protection under which they could continue their work with MSM groups, using the argument that all Ugandans are entitled to healthcare, even in the aftermath of the Anti-Homosexuality Act.

> "The communities don't know about it… so most of these things happen under the carpet, their families don't know…I think it's a process, it's not something that will be accepted overnight, and it will take time for everybody to accept it."
>
> ***A health worker on carrying out the outreach outside bars***

Influencing and responding to the external environment: Time and effort was spent by both organisations in influencing the external environment so that communities and institutions would better understand and support outreach activities rather than hinder them. Interventions of this type – such as the sensitisation of local and religious leaders and training activities with other key community stakeholders, police chiefs and healthcare providers – have been pivotal to avoid security incidents. In light of the dangers and threats associated with a hostile environment, alongside community sensitisation and training, IBU and MAAYGO developed security plans that increased their safety where they worked and enabled them to both mitigate, and quickly respond to, security threats.

Offline and online social networks: Connected to the trusted relationship developed through peers, another fundamental aspect of both models, especially visible in the drop-in centres, is the social, somehow informal, context in which activities normally take place. Far from resembling a clinical environment, the set-up of both models can at times resemble a social gathering. The social dimension of the models contributes to the success of the outreach activities, while keeping the models open to change, to new ideas and propositions. For instance, both IBU and MAAYGO's drop-in centres provide a clear social function for the local MSM community as they have become friendly and safe spaces where MSM can freely express themselves, meet peers and make friends. Moreover, and in response to specific requests from attendees, both organisations have begun offering additional services such as internet access, recreational activities or the possibility of being temporarily hosted at the centre.

> MAAYGO is a place of hospitality where I feel at home. It's not only a place where I come to get condoms and lubricants, but for me MAAYGO is like my family, my second family
>
> ***A MSM client of the drop-in centre***

Results

The SHARP programme was hugely successful in meeting its objective to increase access to, and uptake of, better quality HIV and health services by MSM in the region. It exceeded its original target (to reach 8,280 MSM with at least two elements of the minimum package), reaching more than 14,900 MSM in total.

Tabel 2

COUNTRY	CBO	PLANNED TARGET	ACTUAL CUMULATIVE REACH		
			2013	2014	2015
UGANDA	IBU	1000	317	1,395	2,770
KENYA	MAAYGO	1000	324	2,168	3,161

Lessons learned

As expected, the implementation of two innovative outreach models designed to benefit MSM in contexts where homosexuality is criminalised presented many opportunities to understand what works and what doesn't. It also provided a chance to reflect on the role that MSM-led CBOs can, and should have, in the provision of integrated SRHR and HIV services within the communities they are a part of.

The main lessons learned, which could be useful for other organisations intending to implement an outreach programme for MSM in similar contexts, are outlined below.

Trust is a critical element

From the start of the programme, the challenges associated with promoting and providing MSM with sexual health services in Kenya and Uganda required MAAYGO and IBU to design and implement strategies capable of reaching MSM using non-traditional channels of information and sources of support. This meant reaching beneficiaries through multiple methods, catering for different MSM identities and using new tools and technologies to reach as many people as possible. As explored above, at the core of the majority of these different models exists what could be described as an exchange of trust between the many stakeholders involved in the outreach interventions. The presence and, at time, the absence of trust shaped the way the two outreach models functioned and, ultimately, determined their reach. For instance, when trust was missing, it had to be built, and this meant engaging in lengthy processes of 'fraternisation', of 'becoming better acquainted', of 'exchanging the lack of knowledge with first hand experience'. In this way, trust like a currency, moved from the MSM groups to the MSM peer educator, and from the MSM CBOs to the clinical service providers and back, enabling personal relationships to grow, partnerships to start and outreach to finally take place.

The pivotal role of peer educators

As described above, peer educators were critical enablers of both outreach models, functioning as gateways to the various services provided by the programme. However, mainly due to financial constraints, IBU and MAAYGO were unable to employ their peer educators, and they worked as volunteers instead, only receiving stipends and/or reimbursements for expenses incurred when mobilising peers. The practice of relying on volunteer work, albeit at times necessary, sometimes proved problematic as peer educators, driven by an understandable need to earn a living, were unable to provide consistent commitment to the programme. Peer educators change frequently, forcing the two CBOs to spend additional time and financial resources in training new educators. Ideally, and acknowledging the centrality of mobilisation done through peers, programmes trying to reach MSM in similar contexts should find ways to compensate peer educators for their work.

The programme could have been more successful in engaging MSM over 30-years-old. This is possibly linked to the age of most peer educators, who were between 18 and 30, and who subsequently have relatively 'young' social networks. Future programmes should try to recruit peer educators of various

Caption: Moonlight outreach clinic in Kisumu nightclub district, run by MAAYGO twice a month for MSM to access condoms, lubes, testing, services etc. MAAYGO, Kisumu, Kenya
© Corrie Wingate

age groups, with identities as diverse as possible, so as to maximise the reach of the interventions.

Importance of preparedness and contingency planning

Aware of the attitudes of the general population towards homosexuality in both Kenya and Uganda (and within the specific communities where they operate), the programme partners took various steps to ensure the safety and security of those involved in the outreach models. Some of the arrangements included the development of best and worst case scenario theories of changes before the programme started; conducting security assessments of all programme partners; and instituting a multidisciplinary rapid response team to provide advice following the onset of a crisis. Taking these measures ahead of programme implementation proved successful, because they allowed the programme to have the flexibility it needed to adapt to an environment that could, and did, rapidly change.

When programme implementation started, the social and political environment shaped the outreach models – in certain instances requiring outreach activities to be conducted in a non-visible manner or disguised in ways that wouldn't raise suspicions. During the programme, both CBOs had to temporarily stop their activities or relocate, as seen in the case of MAAYGO.

Similarly, in February 2014, when Uganda enacted the Anti-Homosexuality Act (AHA), IBU had to stop all outreach activities for several weeks as the safety and security of the staff and of the outreach clients could not be guaranteed. Soon afterwards, IBU was supported in revising its service delivery approach to prioritise the safety and wellbeing of all those already benefitting from their services, as well as the security of the partner organisations, and outreach activities were successfully resumed.

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Contact details for further information

To obtain more information on the Sexual Health and Rights Programme (SHARP) in Africa please contact the International HIV/AIDS Alliance at mail@aidsalliance.org

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.