TRUST & CHOICE

FRONTLINE AIDS

INCREASING ACCESS TO HIV SERVICES FOR LGBT PEOPLE IN MOZAMBIQUE & UGANDA

ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live. As a result, 1.7 million people were infected with HIV in 2019 and 690,000 died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

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Front cover: Anselmo Magalhães, EJAF project participant in Mozambique, with community health worker Tauria Rijar.

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Suna Omar, EJAF project participants in Mozambique.

INTRODUCTION

This technical brief presents results and lessons learnt from a two-year HIV programme for and by LGBT people that was implemented in Mozambique and Uganda between 2017 and 2020, funded by the Elton John AIDS Foundation.

Combining evidence-based approaches with innovative community-led and clinical interventions, the programme aimed to provide non-discriminatory HIV and STI services tailored to the diverse HIV and health-related needs of lesbian, gay, bisexual and transgender (LGBT) people. It was based on a four-pronged approach in both countries: community outreach, healthcare provision, strategic LGBT advocacy, and capacity building of LGBT community-based organisations (CBOs). This brief focuses primarily on the community outreach and healthcare provision elements of the project and in particular on what was done to support HIV-negative LGBT people to access HIV prevention services and HIV-positive LGBT people to access HIV testing and treatment services.

The best practices and lessons learnt during the duration of the programme are applicable to LGBT-led community-based and non-governmental organisations looking to establish an LGBT trusted access platform in the community where they operate. They are also applicable for national governments and decentralised health settings that partner with LGBT-led CBOs.

EJAF project participants in Mozambique.

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A focus group discussion with EJAF project participants at AMODEFA, Pemba, in Mozambique.

HIV AND THE LGBT COMMUNITY IN MOZAMBIQUE AND UGANDA

LGBT communities across sub-Saharan Africa are being left behind by many national AIDS responses.

The barriers to being able to access stigma-free healthcare services that are appropriate to their needs are well known within the sector. Blatant discrimination, prohibitive laws and policies, a hostile and sometimes violent environment, the absence of LGBT-specific HIV prevention information, a lack of confidentiality in healthcare settings, and internalised stigma all contribute to discouraging, and at times turning away, LGBT people from routinely accessing HIV and STI prevention, testing and treatment services.

In Mozambique, although same-sex relationships were decriminalised in 2015, there is very little information or data available about how LGBT people are affected by HIV. One key concern is around healthcare professionals not maintaining privacy and confidentiality of test results.[1]

Uganda is one of 32 countries in Africa where same-sex relations are illegal and punishable with life imprisonment. Widespread stigma and fear of reprisals make LGBT people a hidden population and complicate the provision of HIV prevention and continuum of care interventions.

- Key populations and their sexual partners account for 28% of new HIV infections in Eastern and Southern Africa[2], despite making up a fraction of the population
- Of these, 6% occurred among gay, bisexual or other men who have sex with men (MSM)[3]
- Based on 2019 data, only 4% of gay men and other MSM in Mozambique and 12% in Uganda received two or more HIV prevention interventions over a three-month period[4]
- According to the most recent data available, in Uganda the HIV prevalence rate for gay, bisexual and other MSM was 13.2% in 2013[5]
- In Mozambique, a seroprevalence study conducted in 2011 among gay, bisexual and other MSM in three main cities found HIV prevalence at 7%.[6]

WHAT IS A KEY POPULATION TRUSTED ACCESS PLATFORM?

Reaching marginalised, and in some countries criminalised, groups such as the LGBT community with comprehensive HIV and related health services requires a solid foundation to build programmes on.

Such a foundation needs to be rooted within the marginalised community itself and combine community – and clinic-based interventions to deliver HIV services across the continuum of HIV prevention, treatment and care.

A key population trusted access platform is just such an approach. It's a way of improving uptake of HIV and other services for and with key populations that gives people choice and agency, establishing trust between service providers and beneficiaries.

The services provided by the platform are designed around the needs of the key population they intend to serve. They are person-centred. This means that planning, implementation and evaluation of the services must be done in active collaboration with key population members. Thanks to this fundamental partnership, services provided by the platform are tailored to best suit the needs of key population members, increasing their agency and ultimately their access to services.

Importantly, a key population trusted access platform recognises that key population members have different likes and dislikes and that although some needs may be common, some others may not be. For this reason, a key population trusted access platform also maximises choice. This means that services are typically offered in a variety of settings, with varying operational hours and using different providers to meet people's different needs and personalities.

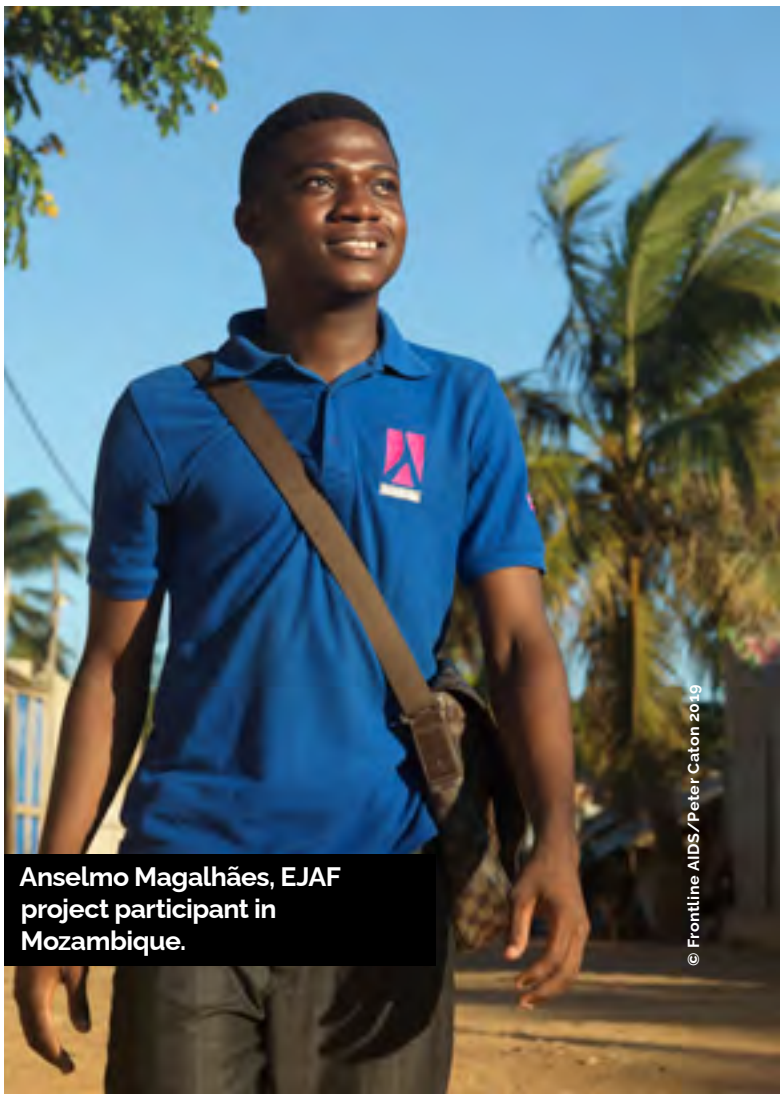
For LGBT people, it means that the LGBT community itself is closely involved in designing a programme that works best for its needs as individuals and as a group.

> **LGBT COMMUNITIES ACROSS SUB-SAHARAN AFRICA ARE BEING LEFT BEHIND BY MANY NATIONAL AIDS RESPONSES**

It also means that LGBT-led organisations and other specialist CBOs are fundamental implementers, working in tandem with health facilities.

While this is not a new approach, it requires precise micro-planning *(see the box below)* at community level by the people who best know and understand the context of the territory where the trusted access platform and its services are to be established.

Grassroots and in particular LGBT-led CBOs have long operated on the frontlines of the HIV response, leading the way in developing innovative and effective programmes responding to LGBT people's needs. They often support public health systems by filling in critical gaps, carrying out community outreach with vulnerable groups that would otherwise be ignored. Active engagement and participation on the part of the LGBT community itself is key to the effectiveness of such programmes.



Anselmo Magalhães, EJAF project participant in Mozambique.

WHAT IS COMMUNITY MICRO-PLANNING?

Community micro-planning is a process through which community-based organisations and particularly key population-led organisations plan and manage outreach activities. Activities – like for instance the delivery of community services – are designed once the project team has achieved a solid knowledge of:

1. The territory, and in particular of the hotspots where beneficiaries normally meet
2. The social networks that make up the community that needs to be reached with services
3. The needs of beneficiaries, including the barriers they face when accessing services.

Critically, peer educators and their supervisors are the cornerstone of any micro-planning exercise as it is their intimate knowledge of the reality that they live in that allows them to make decisions on how to best reach the maximum number of community members. In this sense, community micro-planning makes sure that the people that plan and deliver services for a specific community come from that very same community.

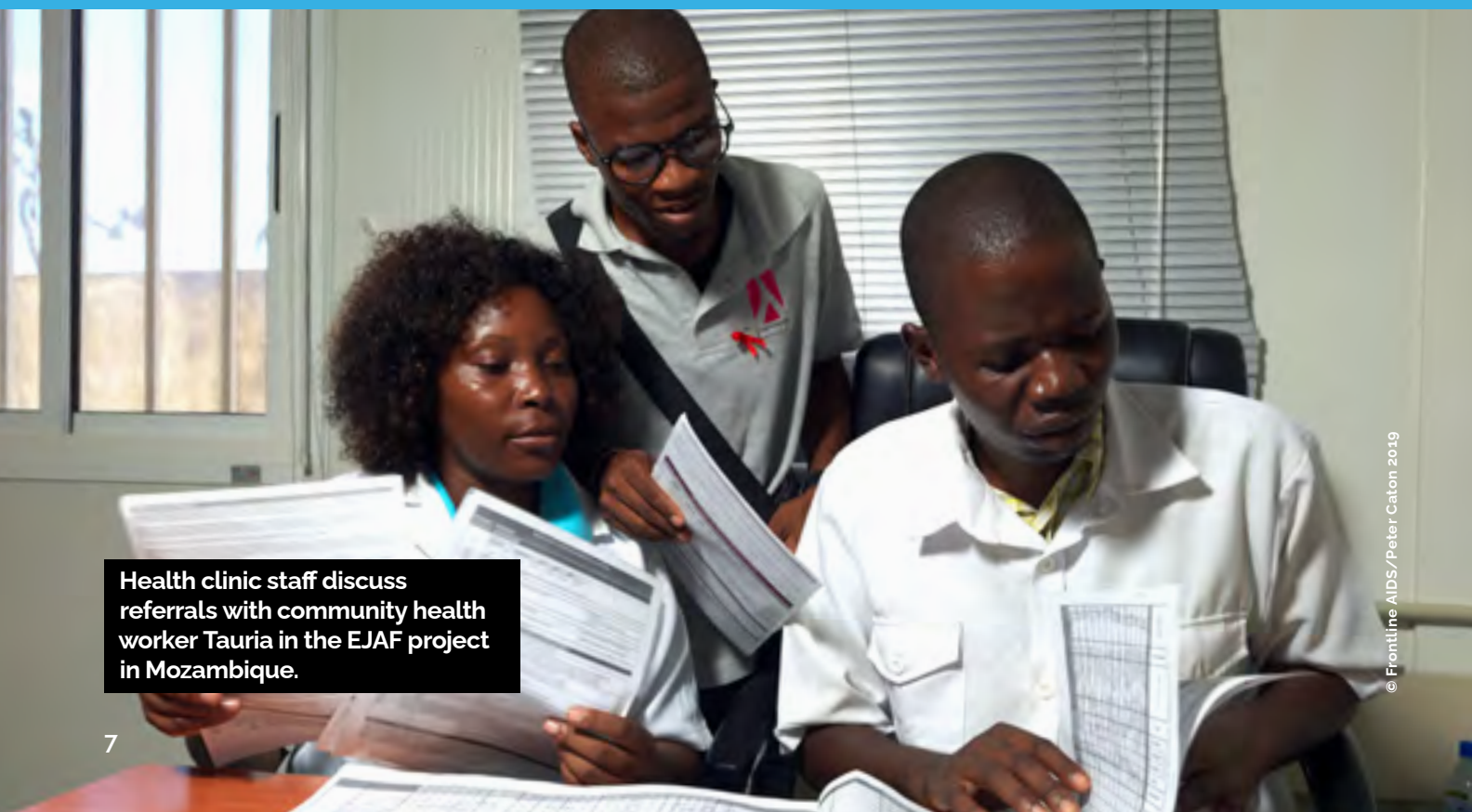
GRASSROOTS CBOS HAVE LONG OPERATED ON THE FRONTLINES OF THE HIV RESPONSE, LEADING THE WAY IN DEVELOPING INNOVATIVE AND EFFECTIVE PROGRAMMES RESPONDING TO LGBT PEOPLE'S NEEDS.

Community micro-planning uses a set of tools that allow community-based organisations to collect and use data on the key population that is being served. These tools are all developed with the collaboration of peer educators and their supervisors and they are then field tested in the communities where they will be used.

The tools normally include:

- → Hotspot map and list (regularly updated)
- → Social network maps
- → Peer educator beneficiary registry
- → Peer educator beneficiary service tracker
- → Weekly and monthly planning tool
- → Weekly and monthly summary tool

Depending on the tool, peer educators and their supervisors update the information on a daily, weekly or monthly basis. The collected information is used on a routine basis to guide the implementation of activities. Importantly, this approach enhances the responsiveness of a programme; supervisors and peer educators are empowered to rapidly identify unexpected results or challenges and encouraged to propose and implement solutions and changes that may be needed. Taking a learning and iterative approach maximises the impact of community- and health facility-based activities and ensures that resources are invested in the right place with the right people.



Health clinic staff discuss referrals with community health worker Tauria in the EJAF project in Mozambique.

HOW TO BUILD LGBT TRUSTED ACCESS PLATFORMS

Trusted access platforms are composed of different elements, all of them existing in the same geographic setting. Each element of the platform provides a specific set of services and is linked to the other elements via clear referral pathways.

As shown in the diagram, the LGBT trusted access platform described in this brief relies on five interrelated strategies to provide HIV and other services to the LGBT community.

1 **Peer educators** reach out to LGBT people in the community where they live, ensuring a continuous presence in all LGBT hotspots.

2 The **LGBT safe space** located in the same neighbourhood offers a place where LGBT people can socialise in a safe environment as well as receive health information and prevention commodities, and access clinical and other types of support and services.

3 The provision of quality stigma-free clinical services is ensured by **LGBT-friendly health facilities** ideally located close to LGBT hotspots and/or the safe space.

4 When possible **mobile clinics** are organised by health facility staff in LGBT hotspots or directly at safe space level.

5 Finally, **structural interventions** support the creation of a secure and welcoming social environment that enables LGBT people to access the other four platform strategies. Such interventions can take place in a variety of settings and can address stigma and discrimination among the general population, and/or promote the safety and security or support the empowerment and agency of LGBT people, thereby increasing confidence and cohesion among LGBT groups.

After a short description of the LGBT programme preparatory stage, the technical brief presents the different strategies of the LGBT trusted access platforms that were set up in Uganda and Mozambique between 2017 and 2020. For each of the five strategies, the brief presents main features, results and pointers for implementers.

ELEMENTS OF AN LGBT TRUSTED ACCESS PLATFORM

STRUCTURAL INTERVENTIONS

- Training of health workers in LGBT-friendly care
- Skills building for LGBT people (empowerment)
- Safety & security training
- Legal protection for LGBT victims of human rights abuses
- Support for decriminalistion/ destigmatisation

HEALTH FACILITY

- Condoms, lubricant promotion & distribution
- Pre-exposure prophylaxis
- Post- exposure prophylaxis
- HIV testing services
- HIV treatment
- HIV treatment adherence
- STI testing & treatment
- HIV monitoring services

MOBILE OUTREACH CLINICS (HOTSPOT & SAFE SPACE LEVEL)

- Condoms, lubricant promotion & distribution
- HIV testing services
- HIV treatment enrollment
- Community dialogues
- STI testing & treatment
- HIV prevention communication

LGBT SAFE SPACE

- Condoms, lubricant promotion & distribution
- HIV treatment adherence clubs
- LGBT toll-free line
- HIV prevention communication
- HIV testing services
- Online/virtual outreach
- Professional psychosocial care

PEER EDUCATION

- Condoms, lubricant promotion & distribution
- HIV prevention communication
- Basic psychosocial care
- HIV testing services
- Community mobilisation

BUILDING THE PLATFORM

Toledo, EJAF project participant in Mozambique, walks with Tauria (left) community health worker.

"THE SAFE SPACE SERVICES WERE THE IDEA OF THE COMMUNITY. THEY WANTED A SPACE WHERE THEY COULD STAY SAFE AND FREE AND LIVE THEIR IDENTITY."

MOZAMBIQUE PARTNER

Focus group discussion with EJAF project participants at AMODEFA in Mozambique.

FOUNDATIONS

The experience of building LGBT trusted access platforms in Uganda and in Mozambique started in both countries with an initial preparatory stage that lasted about six months.

During this phase, the programme invested significant time in community micro-planning activities which included carrying out consultations with the LGBT communities in all the areas where the programme was going to be implemented.

In Uganda and Mozambique, consultations with the LGBT communities were conducted to:

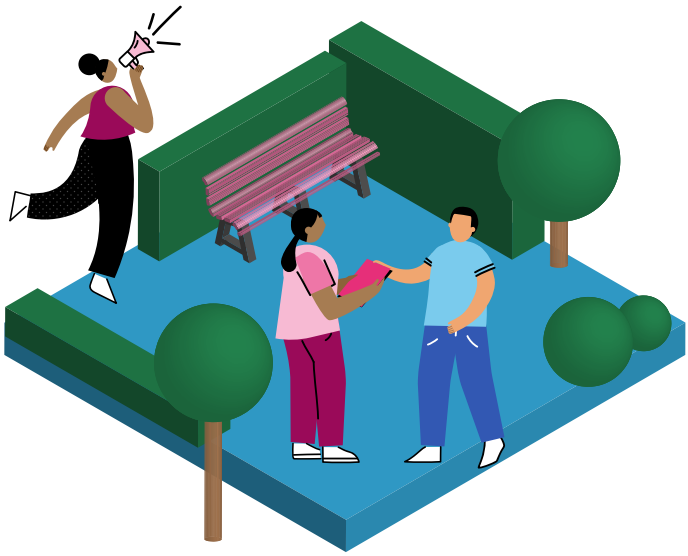
- Map and estimate the size of the LGBT community in all geographic implementation areas.
- Define the community sites and settings visited regularly by LGBT people.
- Obtain information on risk behaviours, risk perceptions and barriers to accessing HIV services for each LGBT group and sub-group.
- Discuss how best to shape community-based and clinical-based services so that LGBT community members could find them accessible, acceptable and affordable.

On the basis of this information, implementing partners and LGBT community members then defined the community- and clinical-based strategies for each implementation area – in this instance LGBT peer-led outreach work, safe spaces, LGBT-friendly health facilities, mobile outreach clinics and structural interventions. In other words, the community itself designed the interventions and products that responded to their needs, and that together create a trusted access platform for LGBT people to access HIV prevention, testing and treatment services in a safe environment.

1

LGBT PEER-LED OUTREACH WORK

A key element of an LGBT trusted access platform is the outreach work conducted by LGBT peer educators in the communities where they live. It is planned and implemented so that a continuous presence can be ensured in all settings visited by LGBT people.



WHAT IS LGBT PEER-LED OUTREACH WORK?

In both Mozambique and Uganda, LGBT peer educators were instrumental to increasing uptake of comprehensive HIV prevention, testing and treatment services by the LGBT community. In general, peer educators are well-respected and trusted people from the LGBT community who introduced other LGBT people to the project and provided them with HIV and STI information and services.

Services included distribution of condoms and lubricants, prevention information, basic psychosocial counselling and linkage and referrals to safe spaces and health facilities participating in the programme. In Mozambique, through partnering with the Ministry of Health, peer educators were additionally trained in HIV testing and counselling and this enabled them to carry out rapid HIV testing in homes, safe spaces and other settings visited by LGBT community members. In Uganda, peer educators could also refer men who have sex with men and LGBT people for oral pre-exposure prophylaxis as well as refer people for free legal counselling in cases of human right abuses or violence.

More than 100 peer educators were recruited in Uganda from all LGBT groups, and more than 60 in Mozambique including two virtual peer educators to manage the project virtual outreach strategy. Additionally, in order to reach different LGBT sub-groups, LGBT peer educators were specifically recruited from a range of age groups and socio-cultural backgrounds. All peer educators followed an initial training course, were provided with an employment contract and paid a monthly stipend.

"WHEN WE DO TEST, WE HAVE A LOT OF COUNSELLING AS COMPARED TO THE HOSPITAL WHERE PEOPLE ARE JUDGMENTAL."

RECIPIENT OF RAPID HIV TESTING, MOZAMBIQUE

Melania de Elsa (left), EJAF project participant, with Lucia, community health worker, Mozambique.

WHAT WERE THE RESULTS?

Peer educators in Uganda and Mozambique cumulatively provided HIV prevention and referral services to more than 34,000 LGBT people. In Mozambique, LGBT peer educators also conducted over 10,250 HIV tests.

In both countries, the overwhelming majority of LGBT people introduced to services by the peer educators were in the 20–35 age group and identified as gay men or men who have sex with men. Reaching LGBT people above the age of 35 was particularly difficult.

In Uganda, the project found that the percentage of men who have sex with men living with HIV identified through peer educators was aligned with the national prevalence data for MSM. However, in Mozambique HIV prevalence among men who have sex with men was found to be significantly lower in the capital Maputo where, based on an existing epidemiological study, it was expected to be higher, and higher in the northern provinces where it was expected to be lower.

In Mozambique, almost two thirds of all the HIV tests that took place as part of the programme were carried out by peer educators. Compared with public health facility workers and nurses working at mobile clinics, peer-led testing initiated a greater number of LGBT people to antiretroviral therapy.

In Uganda, a peer-based contact-tracing coupon scheme offered by implementing organisation TASO was implemented to offer services to LGBT people who could not be reached by peer educators. Through this scheme, LGBT people who attended a TASO clinic were given three coupons and invited to become "seeds". Seeds could refer three of their LGBT friends to the clinic to obtain free health screening, testing and support services. The strategy had a significant multiplier effect, attracting high numbers of LGBT people and, because it does not only rely on peer educator networks, had the potential to reach LGBT people who had not been contacted before.

PUTTING IT ALL INTO PRACTICE – POINTS FOR IMPLEMENTERS

- Peer educators were the cornerstone of the programme. For this reason, it is imperative to plan their job description carefully with the LGBT community to ensure proper recruitment procedures and address training and mentoring needs such as technical, literacy and counselling skills. Regular performance assessments should also be carried out.

- The work of peer educators needs to be fully acknowledged. This means adequate salaries and not simply the reimbursement of transport costs or the provision of material incentives. Peer educators in both Uganda and Mozambique received employment contracts and monthly salaries. In Mozambique, the LGBT-led organisation responsible for community outreach activities decided to significantly increase the salary of peer educators. This decision then had a knock-on effect on the peer educators employed by their other projects, resulting in all of them receiving higher salaries.

- Engaging older LGBT people (especially above the age of 35) was challenging in both countries. To try and correct this problem, after one year of implementation in Mozambique the project decided to recruit only peer educators over 30. This resulted in a modest increase in the age of LGBT people who were reached. Strategies to reach older LGBT people need to be considered from project inception. Importantly peer educators should always be representative of the people who the project is meant to benefit.

- In Mozambique, to bypass some of the barriers that stop LGBT people from testing in health facilities, training some peer educators as HIV testing counsellors was essential. This also enabled the provision of HIV testing in multiple community locations (including in the private and confidential setting of a peer educator's or beneficiary's home). However, not all LGBT people felt comfortable taking an HIV test in this way. For some, accessing HIV testing anonymously in a health facility or when offered by a mobile clinic in a busy hotspot was more acceptable. Offering multiple testing options when providing HIV services to marginalised populations is key.

- Weekly planning sessions, as well as frequent supportive supervision of peer educators' work, are necessary to effectively monitor progress towards achieving programme targets. However, it is important to balance the programme monitoring and evaluation requirements with needing to always ensure the provision of quality care. In Mozambique for instance, peer educators' performance against targets was measured on a monthly basis, and whilst this helped the project to achieve and surpass its testing target, at times HIV testing was offered to LGBT people who were not eligible for the service (either because they had already tested recently, or because they had not been engaging in any high-risk behaviour) simply to reach the monthly target.

2 SAFE SPACES

As implied by the name, safe spaces are a place for marginalised individuals or groups to come together, feel accepted and able to express themselves without prejudice, and share their experiences.

WHAT ARE SAFE SPACES?

In the context of the LGBT community in both Mozambique and Uganda, safe spaces provided a place where LGBT people could socialise, meet friends, attend a range of leisure and skills building activities, as well as a way of accessing non-judgmental, friendly and informed HIV and STI care.

Safe spaces are another important element of building a trusted access platform and complement peer outreach by building trust with the LGBT community, while also providing a secure space for counselling and meetings, and in some cases clinical services.

In Mozambique, safe spaces were established in Maputo City, Maputo province and Nampula province, and in Uganda safe spaces were set up in the cities of Kampala and Mbale. After studying the lessons from an earlier model in Kenya, the implementing organisations held consultations with the LGBT community to establish the best options for where safe spaces could be located securely and optimum opening hours. Sometimes the safe spaces were housed within the offices of an LGBT-led organisation.

Operating as weekday drop-in centres (with occasional weekend opening hours), the safe spaces offered HIV and STI information and support, either in groups or one-to-one with peer educators who also gave regular health talks.

Clinical services were offered at safe space level normally once a week through a collaboration with the HIV clinic participating in the project. Services included the prevention package of services also offered by peer educators, plus STI testing and treatment, and in Uganda, initiation in HIV treatment for LGBT people testing positive.

Safe spaces also play an important role in community empowerment. Social events such as movie nights and karaoke evenings and vocational courses including hairdressing, computer literacy and English were also arranged. Additionally, the safe spaces hosted LGBT people in distress, acting as a shelter for anyone experiencing violence or other human rights violations.

In Uganda, one of the safe spaces hosted a toll-free call line which functioned 24 hours a day, seven days a week. The service provided confidential information, support, counselling and telephone referrals to LGBT people across Uganda who could call in anonymously and without charge.

To assist LGBT people testing HIV positive to maintain long-term adherence to HIV treatment, adherence clubs were initiated in some of the Ugandan safe spaces. The groups, moderated by a trained healthcare worker, met monthly. Participants received medical check-ups, HIV care and counselling, and their monthly refill of HIV medicines. In some clubs, adherence champions were nominated as motivators; electronic reminders and apps were used to manage regimens; and participants shared testimonies and ideas to encourage one another.

TOLL-FREE LINE CALLS IN 2019 BY PRESENTING ISSUE	
PReP and PEP	**32**
HIV testing services/antiretroviral therapy	**259**
Violations/emergencies	**55**
Sexually transmitted infections	**20**
Psychosocial support	**40**
Information, education & communications materials	**8**
Hepatitis B	**13**
TB services	**7**
Adherence groups	**11**
Consumables	**105**
Other/general	**238**
Total	**788**

WHAT WERE THE RESULTS?

The safe spaces were extremely well received by the LGBT community, especially in Mozambique where the concept of a safe locale for LGBT people to socialise was still new. The three centres there received a total of 8,377 visits and proved to be particularly important for members of the transgender community, who for the first time had a social space where they could be completely themselves without fear of discrimination. Attendees also used the safe space to address difficult issues with their families, with parents being invited to attend some of the social events.

In Uganda, the four safe spaces supported by the programme provided clinical services to more than 600 LGBT people. The toll-free line hosted in one of the safe spaces was a much sought-after service with as many as 15 callers a day. Of the 788 calls received in 2019, one third related either to HIV testing services or antiretroviral treatment, and more than 100 LGBT people were subsequently provided discretely with condoms and lubricants. By acting as a first port of call for many LGBT people who had tested HIV positive, the telephone line became a gateway to starting on the HIV continuum of care, for example being connected to pre- and post-exposure prophylaxis services.

As well as being a source of important information about the issues that LGBT people are most concerned about, the call line helped to identify health and disease trends. The call line data also provided an indication of the number of incidences of violence, abuse and discrimination experienced by individuals – all of which is helping to inform advocacy efforts and targeting of services going forward.

The adherence clubs in the Ugandan safe spaces proved to be a very successful way to provide HIV care – all 71 participants (100%) maintained suppressed viral loads. This result is a big improvement from an earlier model, implemented by one of the LGBT-led organisations, where adherence clubs met under the auspices of medical service facilities and in which – according to staff – only 35 out of 125 participants had achieved viral suppression. HIV-positive LGBT people who continue to experience stigma and discrimination reported overwhelming support for adherence clubs in a safe space because accompanying healthcare workers were friendly and compassionate.

PUTTING IT ALL INTO PRACTICE – POINTS FOR IMPLEMENTERS

- In general, the safe spaces in both countries tended to attract younger LGBT people, with the feedback from peer educators being that older LGBT people tend to go to private parties to socialise. As suggested elsewhere in this brief, bespoke strategies to reach older LGBT people need to be considered and designed as part of the inception phase.
- Because the safe space concept was still relatively new in Mozambique, it was critical to work closely with the neighbourhood where the safe space was being set up. Invest time in laying the groundwork and getting buy-in from the community where the safe space is to be situated.
- Observing the highest levels of ethical clinical practice is crucial to ensure that medical and other information is secure. Make sure, for example, that the location of the HIV/STI testing room within the safe space is carefully considered so as to be able to guarantee confidentiality.
- Safe spaces are expensive to operate (the one in Maputo province closed due to cost) – integrating them into an existing office, as was the case in Uganda, rather than as a stand-alone is one possible solution.
- Offering more education and business skills would support safe space users to maintain treatment adherence and risk reduction behaviour. Building links with government agencies, NGOs and private companies that can facilitate vocational training and/or paid employment is one way to do this.

Anselmo Magalhães (in blue), EJAF project participant, with community health worker Tauria Rijar, in Mozambique.

3

LGBT-FRIENDLY HEALTH FACILITIES

Health facilities participating in an LGBT trusted access platform are responsible for the provision of all clinical services.

WHAT ARE LGBT-FRIENDLY HEALTH FACILITIES?

Health facilities participating in an LGBT trusted access platform are responsible for the provision of all clinical services. They are normally facilities where LGBT people access HIV and wider SRHR services that have been specifically tailored to the needs of the different LGBT sub-populations. Typically, healthcare staff working in these facilities have been trained on establishing trust and providing stigma-free care. This is critical as LGBT people often find it difficult to access health facilities for fear of discrimination and being treated badly. Healthcare providers have an ethical obligation to care for and treat people impartially and equitably.

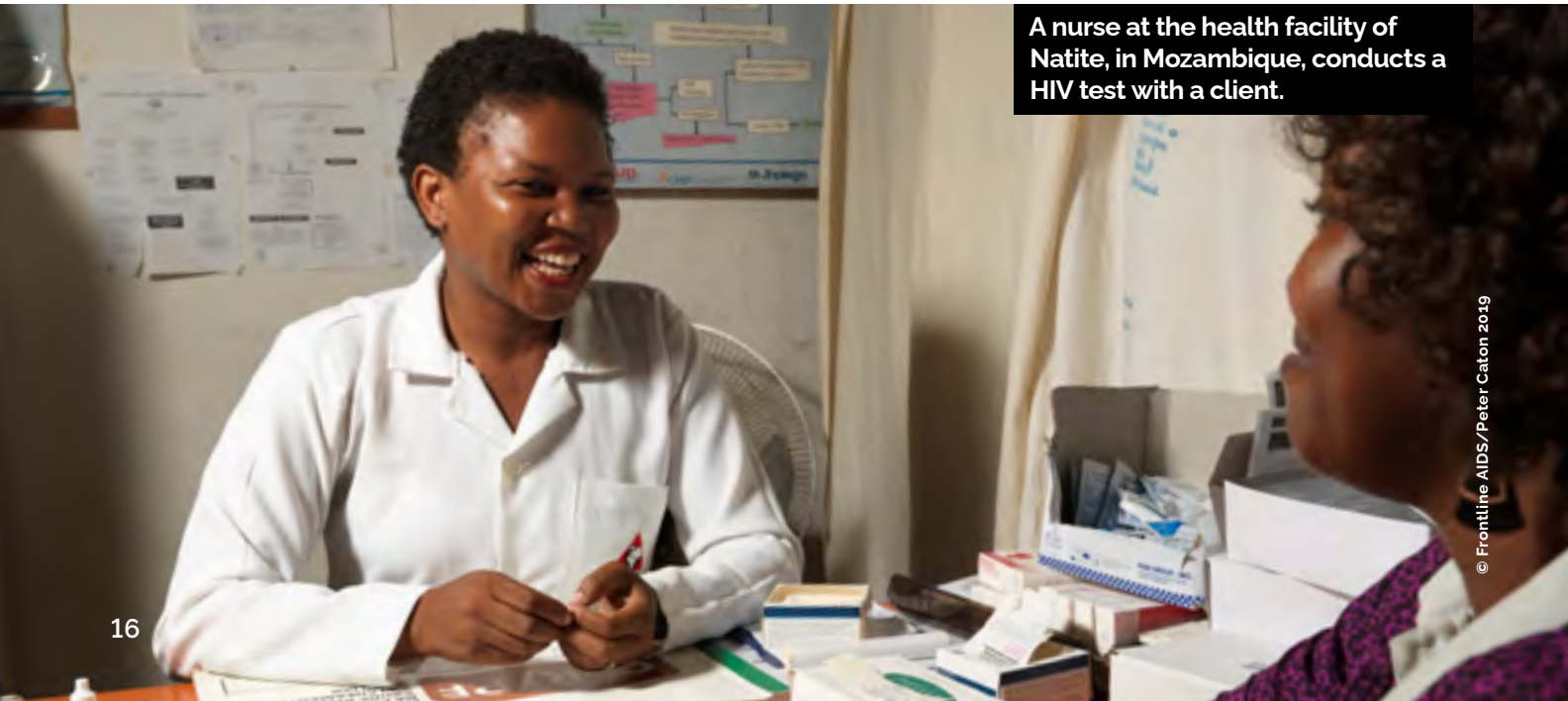
In Uganda and Mozambique, a total of 20 health facilities participated in the programme.

Although most of the services offered are the same as for the general population, the service package offered at clinical level is typically more comprehensive than the one offered at community level as it includes all the medical services that only trained healthcare staff can provide. In Uganda and Mozambique, services only offered by trained medical staff included STI testing, the provision of HIV and STI treatment, all HIV treatment monitoring services, and in Uganda, also pre – and post-exposure prophylaxis.

During their outreach work in LGBT hotspots and among their peers, LGBT peer educators promote regular medical check-ups at the nearest health facility. In some of the trusted access platforms established in Uganda and Mozambique, they were also stationed at an LGBT-friendly health facility on fixed days to support LGBT people in navigating the medical care system and accessing the services they needed.

All LGBT people testing HIV positive in community settings during the course of the programme were accompanied to – or when this was not possible referred to – LGBT-friendly health facilities. Once there, they were usually asked to repeat the HIV test by way of confirmation and then offered the chance to begin taking antiretroviral treatment (ART).

In Uganda, LGBT people who had been taking ART for some time and achieved viral suppression (or a very low amount of the HIV virus in their bodies) were eligible to attend ART adherence clubs organised at safe space level (see safe spaces section).



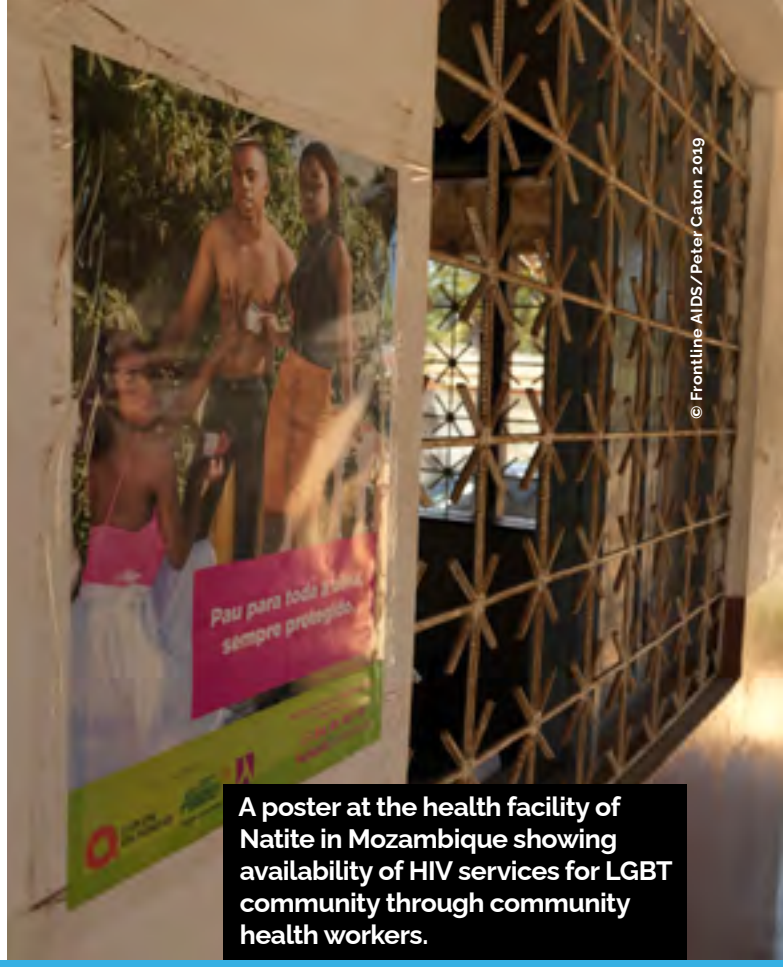
A nurse at the health facility of Natite, in Mozambique, conducts a HIV test with a client.

WHAT WERE THE RESULTS?

Health facilities in Uganda and Mozambique cumulatively provided HIV services (including HIV testing) to more than 3,000 LGBT people; the vast majority of them identified as gay, bisexual or as men who have sex with other men.

In both countries, most LGBT people testing HIV positive were identified in a community setting. However, to be enrolled on HIV treatment they were all referred on to the nearest LGBT-friendly health facility.

In Uganda, 92.6% of people who tested positive were successfully linked to an HIV clinic and more than 80% started taking HIV treatment. In Mozambique, however, linkages to HIV care and initiation to treatment were more problematic and results varied considerably between implementation areas. In Nampula province, more than 75% of HIV positive beneficiaries were successfully linked to care and started HIV treatment, whereas in Maputo province only about 60% of all LGBT people testing positive were linked to care and just over 56% started treatment.



A poster at the health facility of Natite in Mozambique showing availability of HIV services for LGBT community through community health workers.

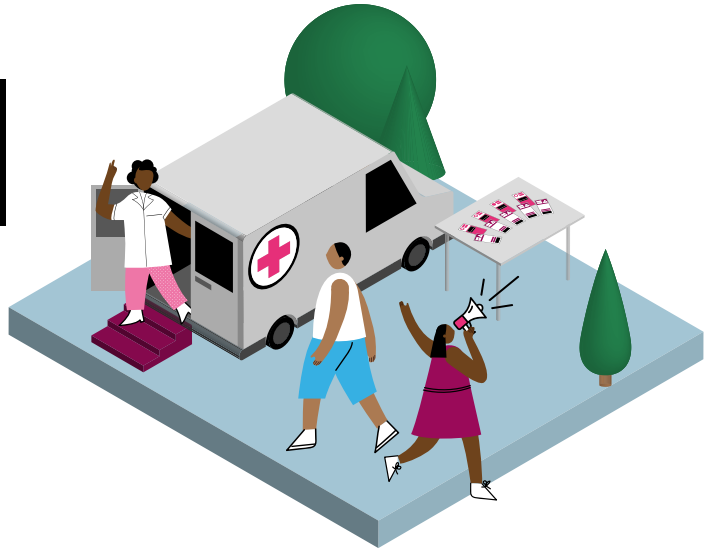
PUTTING IT ALL INTO PRACTICE – POINTS FOR IMPLEMENTERS

- The health facilities participating in the programme should be chosen to be part of the LGBT trusted access platform by the LGBT community members. In the vast majority of cases in Uganda and Mozambique, their decisions were based on enablers such as the perceived friendliness of staff attitudes towards LGBT people, overall quality of services provided, and proximity of the facility to people's homes.
- In Mozambique, the health facilities where staff had established regular relationships and coordination activities with LGBT peer educators were also the ones that more successfully linked to care LGBT people who tested HIV positive during community testing.
- In Mozambique, having noticed that a significant number of people testing HIV positive were not linking to HIV care, LGBT peer educators living with HIV were recruited to support newly diagnosed people to navigate the HIV care system. Although this initiative was implemented towards the end of the programme, during the project evaluation it was considered by health facility staff to be a valuable strategy to improve outcomes in the HIV continuum of care.
- Programme staff in both countries found that health providers' attitudes towards LGBT people can be a barrier to service uptake. As described under the structural interventions section, it was essential to provide initial training courses and mentoring activities to sensitise health workers on the needs of LGBT people, focusing on correcting negative attitudes and on values clarification. To this end, LGBT people were invited to attend the health worker training sessions, developed by Anova's Health4Men project, to create acceptance and increase understanding.
- Healthcare workers in public health facilities typically work long hours and already have various responsibilities. Obtaining their collaboration can be challenging. For this reason, when partnering with public health facilities, it is important to consider programme strategies that simplify or decrease the workload of health workers rather than adding to it.
- Similarly, it is critical to invest time during the programme start-up phase to obtain buy-in from the health department in order to generate a fruitful collaboration with Ministry of Health officials and health facility staff.

4

MOBILE OUTREACH CLINICS

Mobile outreach clinics enable the delivery of clinical services for a limited duration in places where they are not generally available.



WHAT ARE MOBILE OUTREACH CLINICS?

In Uganda and Mozambique, mobile outreach clinics have been adopted to offer safe and confidential HIV prevention, testing and treatment services beyond the health facility doors, expanding choices for LGBT people.

As another building block of a trusted access platform, they engage communities and build trust and participation, by bringing services directly to people who might otherwise be reluctant to visit a formal health facility.

In Mozambique, operating in known LGBT 'hotspots' like clubs, festivals and beachfront areas, weekly stigma-free mobile clinics were held on weekend nights in Maputo and Cabo Delgado provinces. Locations were selected in consultation with the LGBT community and reviewed regularly as the popularity of hotspots changes over time.

An EJAF project participant in Uganda being offered HIV testing and counselling.

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In Uganda, mobile outreach clinics were conducted in pre-identified urban venues as in Mozambique, but also in underserved and remote parts of the country where groups of LGBT people were known to not have access to HIV services. The mobile outreach clinics were held during the week and over the weekend, usually in the afternoons and early evenings.

Staffed by peer educators as well as clinical nurses, the mobile clinics in both countries offered HIV testing, STI testing and treatment, basic psychosocial counselling, and distribution of male and female condoms and lubricants to all LGBT people attending. In addition, information on HIV prevention was provided to those testing negative, and referral to HIV treatment was provided to those testing positive. In Uganda, LGBT people testing positive were also offered the possibility to start taking HIV treatment right away. A starter pack of antiretrovirals was provided, and individuals were advised to visit a health facility in the following days to receive a drug refill.

In Uganda, one of the implementing partners also integrated community dialogues into the mobile clinic outreach model. During a mobile clinic, this technique adopted peer-led approaches to sensitise and mobilise LGBT communities on their rights to access health services. As well as holding facilitated conversations about HIV and SRH-related topics, the sessions provided a platform for LGBT people to air concerns over treatment or to discuss issues concerning sexuality and HIV.

Topics selected for discussion were informed by the community's needs and prepped in advance at monthly planning meetings by LGBT peer educators. Subjects included condom use, STIs, HIV prevention options and the right to health.

Importantly, mobile outreach clinics can also be conducted within an LGBT safe space. This may happen occasionally or at regular intervals (weekly/monthly) which has the benefit of establishing a routine that LGBT community members can rely on and plan their visits to the safe space accordingly.

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WHAT WERE THE RESULTS?

Mobile clinics in Uganda and Mozambique were attended by more than 8,800 LGBT people, and more than 90% of these accessed HIV testing and received their results.

The services provided by the mobile outreach clinics responded to issues experienced at health centres such as lack of confidentiality, and stigma and discrimination. The mobile outreach clinics were chiefly appreciated for their ease of access together with the opportunity to receive follow-up support, and as a trusted source of information and a safe space. Having them at a distance from home communities was an advantage for people who did not want to be identified as LGBT by their relatives or friends. Asking peer educators to mobilise community members resulted in a proactive approach that acknowledged people's potential stigma, isolation, fear, and vulnerability in the context of HIV.

In Mozambique, where mobile clinics were mainly organised at night and over the weekend, LGBT people as well as health workers welcomed the strategy as a much-needed new intervention. Many people may have limited access to their local health unit during the day and having mobile clinics at night was ideal for people who, due to HIV stigma, avoided accessing HIV testing at the health facility.

PUTTING IT ALL INTO PRACTICE – POINTS FOR IMPLEMENTERS

- In Mozambique, the overall HIV positivity rate of people attending the mobile clinics was below expectations. This was mainly because the positivity rate varied considerably from venue to venue, with some venues obtaining positivity rates close to 0. This stressed the importance of constantly reviewing the selection of LGBT venues as 'hotspots' may change frequently.
- Whereas in Uganda, LGBT people testing positive at the mobile clinic could be offered HIV treatment right there and then, in Mozambique Ministry of Health (MoH) guidelines did not permit people living with HIV identified in mobile clinics to start HIV treatment right away. This meant that LGBT people testing positive could only be referred to a health facility. With the mobile clinics taking place over the weekend, people were asked to visit a health facility the following week. This in turn made it complicated for project staff operating the mobile clinics to ensure and track linkage to care of people who tested HIV positive in a mobile clinic. Thankfully, this problem has now been rectified by a revision of the MoH guidelines which will now also allow the provision of HIV treatment during mobile clinics.
- In Uganda, when mobile clinics were organised in remote areas, in order to ensure retention in HIV services for LGBT people testing positive it was necessary to make arrangements with local HIV clinics so that each beneficiary could receive appropriate follow-up care afterwards.
- In mobile clinics holding community dialogues in Uganda, using LGBT peer educators as mobilisers ensured high levels of participation as people were able to identify closely with them. By working with a facilitator, the LGBT community sought to find its own solutions for local problems at a forum that was viewed as a safe environment for conversation.
- The community-driven aspect of community dialogues is particularly important to emphasise as participants need to have shared ownership of the process, so working with a competent facilitator who is able to speak the local language – and who does not always play the role of 'educator' – is key.
- In both countries, where clinics operated near clubs and bars, occasional security issues arose. These can be mitigated by ensuring that strong risk management procedures are put in place.

5 STRUCTURAL INTERVENTIONS

Supportive legislation and policy; addressing stigma and discrimination, violence and human rights violations; community empowerment; and ensuring access to health services are all considered critical enablers of an effective HIV response for marginalised populations.

WHAT ARE STRUCTURAL INTERVENTIONS?

In order to tackle the factors and obstacles that block such critical enablers from being put into effect, structural interventions are needed to make the local environment safer for marginalised populations and reduce barriers to accessing HIV services. A trusted access platform should provide opportunities for tackling the issues at a local level with community members so that their ability to self-advocate is built up in the process.

Some of the structural interventions deployed in the Uganda and Mozambique programmes were as follows:

- **Stigma-free care**
  In Mozambique and Uganda, diversity training for health workers based at public health facilities took place to try and decrease facility-based discrimination and stigma towards LGBT people. The training explored non-stigmatising HIV care, interventions that address inequality and non-discrimination, and health care as a human right. LGBT people were invited to attend too in order to foster acceptance and increase understanding of their specific health needs.

- **Legal support**
  In Uganda, the programme aimed to orient 60 LGBT peers on laws and policies affecting the LGBT community's access to HIV services. One of the programme implementers, a human rights community-based organisation, trained paralegal officers – mainly LGBT people – and strengthened the legal literacy of LGBT peer educators on the rights of LGBT people to access legal services. During these sessions, participants were introduced to the legal system in Uganda, the concept of human rights, and the laws and policies that affect LGBT people and people living with HIV, with a particular emphasis on the HIV Prevention and Control Act.

  The same organisation also provided legal advice and support to the Ugandan consortium on issues relating to national laws and policies on discrimination and the stigmatisation of LGBT people. This included legal advice on how to respond to reported incidents.

- **Decriminalisation and destigmatisation activities**
  In both Mozambique and Uganda, one of the main advocacy partners worked closely with implementing organisations to build and assert the power of LGBT people to secure quality, stigma-free health services. In Uganda, this included supporting the establishment of Uganda's first Key Population Consortium, a pressure group led by marginalised populations that focused explicitly on policy and advocacy regarding the right to health. The same organisation also supported HIV and LGBT organisations to arrange meetings with representatives from the US and Ugandan governments to escalate concerns.

  Another LGBT-led advocacy partner used its seven-step programme to engage with key policy and decision makers at Uganda's Ministry of Health. The project also funded key population stakeholder engagement meetings, coordinated by the Ministry of Health, which encouraged learning and discussions on issues affecting LGBT people and their access to services.

- **Community empowerment**
  Building the capacity of both community and programme staff entailed allocating dedicated resources and creating support mechanisms for training, monitoring, supportive supervision and encouraging community involvement in influential fora. Weekly catch-up calls, regular in-country support visits, and significant time invested in upskilling staff and peer educators all formed an essential part of the process and helped to strengthen programme implementation.

  Additionally, self-help groups contribute towards community systems strengthening (CSS) by empowering the target community to take steps to solve certain problems or issues, a role fulfilled in this instance by the Ugandan adherence clubs and community dialogues.

WHAT WERE THE RESULTS?

- In Uganda and in Mozambique more than 140 healthcare professionals participated in the training provided by ANOVA's Health4Men project on quality and stigma-free HIV and STI services for LGBT people.
- The friendly services available at public clinics greatly expanded the access for LGBT people, especially in rural areas (so-called 'last mile' health care) in Uganda where service-based implementing partners had no presence.
- Another Ugandan implementing organisation found that at Mbale hospital – where a doctor, five nurses and two counsellors had all attended the training for healthcare workers – a particular ward had been created for LGBT people offering friendly services.
- In Uganda, advocacy partners organised the first national meeting of the Uganda Key Populations Consortium (UKPC) made up of more than 70 key population-led civil society organisations and networks. Its goal is to support and coordinate advocacy, policy analysis, lobbying, monitoring and accountability efforts in the areas of HIV, health policy and human rights.
- The seven-step advocacy programme, implemented by one of the organisations, influenced the Ugandan Ministry of Health to start to talk publicly about programming for marginalised populations which had never happened before.

Some of the EJAF project participants in Mozambique.

PUTTING IT ALL INTO PRACTICE – POINTS FOR IMPLEMENTERS

- The training of health care workers is a lengthy process that required multiple training events to ensure that they are sufficiently prepared to support and care for LGBT people. Health care workers change jobs, and hospitals and clinics restructure so ensuring that an LGBT person testing HIV positive will be referred to a service that is prepared and welcoming is crucial.
- One idea, which has already been piloted in Kenya, is to set up health facility mentorships which as well as focusing on the healthcare providers should also include other personnel such as hospital security and receptionists in order to address stigma and discrimination.
- As demonstrated in Mozambique, collaborating with the Ministry of Health on the training of health workers could help to maintain many of the programme's ambitions. Ensuring that this kind of training is included in the national training curriculum for health workers is an important part of the process.

CONCLUSION

By integrating LGBT community-led outreach approaches and clinic-based interventions, the programme was able to deliver many of the key elements of a trusted access platform.

External evaluations in both Uganda and Mozambique found that the different interventions implemented during the two-year projects generated demand and uptake of tailored HIV and STI services by the LGBT community. This could only have happened by creating a bond of trust and participation with the target population and by providing stigma-free services informed by and responding to its specific and evolving needs.

The programme's interconnected approaches and combination of methodologies meant that LGBT people who ordinarily would have remained hidden were reached and community members who tested HIV negative were able to access prevention services, decreasing their vulnerability to HIV infection. Spearheaded by LGBT community-based organisations, the partnership model not only gained buy-in from healthcare providers but, just as significantly, was able to solicit assistance from the Ministry of Health in both Mozambique and Uganda. This in turn has built links with government, helping to strengthen the HIV treatment cascade for LGBT people.

The programme results demonstrate that setting up trusted access platforms in order to provide services to LGBT people was a successful initiative. LGBT trusted access platforms organised in Uganda and Mozambique expanded access to quality HIV and SRH services and each of the strategies was very well received by the LGBT populations. Increasing the involvement of LGBT organisations in the delivery of services would have a major impact on tackling national HIV responses. One way of doing this would be to ensure that they are fully equipped with the skills and resources needed to sustain the model of cooperation shown by the project.

Scaling up is only possible however if the funding is in place. Many of the strategies outlined in this case study are only likely to continue if they are absorbed into other programmes run by the implementing partners, or if they are taken over by government or large donor programmes such as those supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Smaller LGBT organisations are particularly at risk. They know their community better than anyone and, having seen what works, should be invested in to maintain momentum.

Much more needs to be done to convince political leaders, government officials, health workers, police officers and educators of the role that LGBT-led community organisations play, and the impact that they have on LGBT people's lives. The results demonstrated by the Mozambique and Uganda programmes in this technical brief are an indication of what could happen if national governments were to support the setting up of trusted access platforms for LGBT communities in the first instance and then were to sustain them once operational. With key populations and their sexual partners now accounting for 62% of new HIV infections globally[7], implementing tried-and-tested interconnected innovative community-based approaches to reach them should take the utmost priority.

Peer educators in the EJAF project outside Hope Mbale's office in Uganda.

	THE LGBT PROGRAMME AT A GLANCE	
	Mozambique	**Uganda**
Who	→ 1 LGBT-led organisation → 1 community-based organisation → 2 international organisations	→ 10 LGBT led-organisations → 3 community-based organisations → 2 international organisations
Where	Maputo Province Maputo city Cabo Delgado Province Nampula city	In over 20 districts, but with most activities implemented in the cities of Kampala, Entebbe and Mbale
When	July 2017 – June 2019	January 2018 – March 2020
Budget	2 million USD circa	2 million USD circa
	Programme objectives	
Community outreach	At community level offering a basic package of HIV services to all LGBT people, supporting HIV negative people with preventive services and HIV positive people in accessing HIV care. Package included HIV rapid testing (at home and in the community); active referral and linkage to prevention services and HIV care; tracking of LGBT people not retained in HIV care; peer-based adherence support and differentiated care; condom and lube distribution; counselling and psychosocial support; referral to legal and emergency support.	
	→ 60 peer educators → 3 safe spaces	→ 100 peer educators → 4 safe spaces
Clinical Services and HIV care	At clinical level offering a comprehensive package of HIV services to all LGBT people accessing health facilities or mobile clinics. The comprehensive package included all elements of the basic package plus HIV and STI diagnosis confirmation and treatment; CD4 and viral load monitoring; pre – and post-exposure prophylaxis (Uganda only); professional counselling and psychosocial support; adherence support; and tracking LGBT people not retained in care.	
	→ 10 health facilities → 2 mobile clinics teams	→ 10 health facilities → 4 mobile clinics teams
Structural interventions	→ Capacity strengthening initiatives for all national level implementers, including all LGBT-led organisations → Training and mentoring health workers in the provision of quality and stigma-free care for LGBT people → Skills building initiatives in empowerment for LGBT community members → Safety/security – implementation of a human rights monitoring system to collect evidence and respond to human rights violations	
Strategic Advocacy	Advocacy activities to lobby for priorities identified by the LGBT communities that advance the health, rights and overall wellbeing of LGBT people.	

Toledo, EJAF project participant in Mozambique, with Tauria, community health worker.

ENDNOTES

1 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0228307

2 https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

3 https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf

4 https://www.unaids.org/sites/default/files/media_asset/fourth-annual-progress-report-global-hiv-prevention-coalition_en.pdf

5 https://kpatlas.unaids.org/dashboard

6 https://www.researchgate.net/publication/266027719_Men_Who_Have_Sex_with_Men_in_Mozambique_Identifying_a_Hidden_Population_at_High-risk_for_HIV

7 https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

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