CCM SITE VISIT TO CEPEHRG

1. INTRODUCTION

On the 1st November 2018, the HIV/TB oversight committee conducted an evening site visit to a CEPEHRG project in Labadi, Accra to learn about HIV services provided to Men who have Sex with Men (MSM).

The objective was to:

I. Allow new OC members to understand implementation of HIV prevention projects targeting MSM
II. Understand delivery of services offered on sexually transmitted infections and knowledge, attitude and behaviors of the project's beneficiaries
III. Ascertain availability of condoms & lubricants and any reasons for low utilization.
IV. Get more information about the ways of linkage to treatment, successes and challenges
V. Identify any difficulties faced by MSM with regards to human rights and community acceptance.
VI. Identify opportunities for improvements in grant implementation

Initially, the team had a joint discussion with eleven beneficiaries of the project and two peer educators. Some team members additionally had individual discussions with selected beneficiaries which helped to touch upon more sensitive topics. There was also a separate discussion with the peer educators only. One team member also talked in a one-on-one conversation with a case manager. Unfortunately, time did not allow additional discussions with the CEPEHRG project team but follow up calls were done to obtain addiditonal information. The discussions with the key respondents took place in Ga, Asante Twi and English.

2. ACRONYMS

ART	Antiretroviral Therapy
DIC	Drop In Center
HTS	HIV Testing & Counselling
IEC	Information, Education, Communication
KP	Key Population
MSM	Men who have Sex with Men
OC	CCM Oversight Committee
PE	Peer Educator
PLHIV	People Living with HIV
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infections
TB	Tuberculosis

3. FINDINGS

3.1 Summary of challenges and recommendations

No	Findings	Recommendations	To whom
1	Contradictory statements from CEPEHRG office staff and Peer Educators on the number of MSM reached and the targets	Clarify targets per PE	CEPEHRG
2	Newly enrolled MSM are the least engaged (once per quarter) in IEC activities	Concentrate efforts on newly enrolled clients to improve their HIV/STI knowledge quickly	CEPEHRG
3	Low level of knowledge on STIs among PEs. No IEC materials specifically on STIs	Test all PEs on their STI and HIV related expertise. Consider a survey among beneficiaries on their STI/HIV related knowledge. Ensure availability of picture books on STIs.	CEPEHRG WAPCAS
4	Low / no condom use. Low number of condoms (129) distributed during the first semester 2018. Some beneficiaries complain that they have never been offered a condom by their PE	Develop innovative strategies to enhance condom use. Review how condoms are distributed.	CEPEHRG
5	High prevalence of symptoms suggestive of STIs among key respondents	Ensure better STI expertise of PEs. Make IEC materials available. Inform all beneficiaries on the closest DIC/KP friendly health services	CEPEHRG WAPCAS
6	Low awareness of drop-in-centres and CHRAJ complaint system	Ensure that info on DICs and KP friendly services is part of every sensitization. Same for CHRAJ	CEPEHRG
7	Low HTS rate	Investigate reasons of low HTS uptake and adjust the strategy	CEPEHRG
8	Contradictory statements on number of PLHIV on treatment (office staff vs. case manager)	Harmonize reporting	CEPEHRG
9	ART centers insist on costly lab tests as a condition for enrollment on ART	Develop referral system to ensure that all lab tests can be done free of charge	NACP

4. CEPEHRG

CEPEHRG has been implementing Global Fund supported activities since round 8. Currently, CEPEHRG is an sub recipient under WAPCAS. The organization works in 11 districts of four regions, i.e. Eastern, Greater Accra, Ashanti and Central Regions, and implements activities targeting MSM with quality information on HIV, STI, HTS, SGBV, Stigma, Human Rights (minimum package of services) according to the Key Population Standard Operating Procedure.

4.1 The site visited

CEPEHRG started provision of MSM HIV prevention services at the site visited about five years ago. The site is split up into two micro sites (La Maamli / La A and La Trade Fair-Tse Addo / La B) that have one Peer Educator each and one Case Manager. At both microsites together, there are about 100 MSM. The site does not have a drop-in center which beneficiaries consider as a serious lack. Referrals are usually done to LEKMA hospital, Tema General Hospital, or Ridge Hospital.

4.2 Services offered

The services offered to the target group by the Peer Educators remain largely the same as under the previous grant cycle, i.e. information on HIV and other STIs, HTS promotion, TB screening, condom demonstration, promotion and distribution, and referral services. The majority of engagements with the MSM is 1:1, mostly in the comfort of their homes. What is new in NFM2 is linkage to care: a dedicated case manager assures that men who tested HIV+ have access to ART and adhere to treatment.

4.3 Peer education

Each of the two PEs have been working for almost two years and have a quarterly joint target of reaching out to 43 new contacts each quarter or 172 per year. This is much more than the 100 men at the site but the Field Supervisor explained that the PEs reach additionally out to friends and partners who do not necessarily frequent the microsites themselves (snowball effect). While the PEs said that they attend to 36 MSM each, CEPEHRG data indicate that as of the first semester, 60 new contacts have been reached and as of quarter three 200. This sounds like a contradiction that should be investigated. Unfortunately, both PEs had left in the meantime and could not be reached for clarifications.

In the beginning of 2017, the PEs received a one-week training that they consider as adequate even though they expressed a need for more training on how to effectively engage new members who are either not interested in HIV and STIs or who fear stigma when being seen with the PEs. Both PEs expressed satisfaction with their work. They work full time, partly also on weekends.

Frequency of engagements: Usually the PEs visit the community members at their homes for their one-on-one engagements, which tend to last between 30-90 minutes. All key respondents (beneficiaries) reported at least one engagement with a PE in the past three months. Six members reported at least two meetings and 4 members reported three or more

conversations with the PEs. However, it is regrettable that particularly new members seemed to have had only one peer education session during the past quarter, considering that they have probably the biggest need of additional information on HIV/STIs.

Knowledge transfer on STIs: While the majority of the beneficiaries the team talked to had bothersome symptoms indicative of STIs, none of them seemed to see the urgency to have them diagnosed and treated. The team inquired specifically with the PEs which IECs they use to inform their peers about other STIs than HIV. The PEs did not have any materials with images of STI symptoms. The team then asked them about the STIs they educate their peers about and was very concerned when the PEs could not name or describe a single STI beyond HIV. Also in terms of HIV, the peer educators' knowledge appeared rather superficial. It is highly advisable to verify the PEs' knowledge on HIV and other STIs and to consider a refresher workshop if necessary.

4.4 Condom availability and use

Both condoms and lubricant have been consistently available throughout 2018 according to the PEs. In this context it is hard to understand why in the first semester only 129 condoms and 85 doses of gel were distributed (CEPEHRG data). In the third semester, distribution picked up and reached cumulative 2592 condoms and 956 gel units. Condoms are distributed free of charge to the members. While the PEs claim that they hand out condoms consistently during each engagement with members, particularly new members complained privately that they have never been offered a condom. When the PEs were confronted with this allegation, they informed the team that some members always refuse condoms.

A poll through hand sign revealed that of the eleven MSM present, no one reported consistent use of condoms while four indicated that they never use a condom. On further interrogation about the reasons for inconsistent and no condom use, MSM attributed it to pain during sex with condoms ("I like it rough"), the tightness of the condoms, and their unavailability at the point of sexual activity. Most MSM who were engaged in individual conversations confided symptoms indicative of STIs to the team that remained untreated. The team made them aware that any STI that they acquire through unprotected intercourse could as well be HIV and urged them to get treatment and use condoms consistently.

4.5 HTS

An HTS campaign is organized once per quarter. The PEs reported that in their groups of 36 community members each, 26 community members were tested for HIV in one group and 15 in the other. There is certainly potential for improvement. The confirmation test is carried out at the hospital, not onsite.

4.6 Linkage to care

The MSM contacted were unhappy about the lack of a DIC in proximity. While beneficiaries knew that they could theoretically get treatment at any health center, they would prefer a DIC in which they would not have to fear any stigma. However, most of them claimed that they

would not know where to go in case of an STI. There reportedly is a DIC not too far away from the site; its location does not seem to be part of the peer educating conversations though.
The case manager is always present during the HTS exercise. While he claimed that he was taking care of three HIV+ men, CEPEHRG data indicate that four men were tested positive between January and September 2018 but none is on treatment. The CCM team did not fully understand the background of this contradiction and leaves the investigation up to CEPEHRG/ WAPCAS. The case manager explained that he is taking care of HIV+ men outside the site but could not explain how those are documented or reported.
The following is hence the transcription of the statements of the case manager: Once a MSM tests reactive for HIV, the nurse accompanies him to a hospital for a confirmation test, usually LEKMA, Tema General or Ridge Hospital. The case manager starts following up once HIV is confirmed. He has never had an issue with wrong telephone numbers and could hence connect with everyone tested positive. On a daily basis, he contacts the PLHIV through phone and through SMS and reminds them of their appointments at the ART clinic. He sees his clients at least three times per month to provide adherence counselling and moral support. Because of this frequent contact, he has not had any challenges with defaulting. He however complained that most hospitals still insist at partly very costly lab test before PLHIV are enrolled on ART. If the PLHIV is not able to pay for those tests, CEPEHRG takes up the cost.
The case manager never experienced a situation in which either First Response, Oraquick at the ART center, or ARVs ran short. Depending on the stability of the client, they receive a one to three month supply.
Even though he only had initial training, he is continuously learning more about HIV/AIDS through the internet. All in all, beside the contractions experienced, the case manager seemed to be on top of the issues and be very committed.

4.7 Other

The community members shared the following challenges with the team:

a) Cost of treating STIs other than HIV a burden (particularly warts), especially since most MSM the team met with identified as unemployed
b) Blackmailing among MSM as a result of the poverty
c) Pilfering from partners
d) Low awareness of the CHRAJ discrimination complaint system

5. TEAM MEMBERS

- Annekatrin El Oumrany (CCM Secretariat)
- Benjamin Cheabu (CCM Secretariat)
- Ernest Ortsin (GHANET)
- Evans Opata (GCNM)
- Genevieve Dorbaye (TBVN)

6. KEY RESPONDENTS

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11 beneficiaries of the project		