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# REACHING MEN WHO HAVE SEX WITH MEN IN GHANA THROUGH SOCIAL MEDIA: A PILOT INTERVENTION

Kimberly Green, Philippe Girault, Samuel Wambugu, Nana Fosua Clement and Bashiru Adams

## Abstract

*The prevalence of HIV among men who have sex with men (MSM) in Ghana is more than 15 times greater than the prevalence of HIV among adult males in the general population. The prevalence of HIV among MSM in Accra and Kumasi is 34.4% and 13.6%, respectively. In 2012, the USAID Ghana SHARPER project — which supports HIV prevention and care among MSM — reached less than half of the 30,000 estimated MSM at the project sites. In 2013, SHARPER tested the use of social media by MSM community liaison officers to identify unreached MSM networks. We reached 15,440 unique MSM through social media, and 12,804 MSM through traditional outreach activities involving peer educators. The combined total of 28,244 MSM represented 92% of the estimated number of MSM in the country. There was little overlap among the MSM reached by the two methods. The use of social media is a very important avenue for reaching MSM who are not reached by peer educators in Ghana. The method should be adopted as an integral outreach approach for HIV-prevention interventions in the future.*

**Keywords:** MSM, HIV, social media, peer education, Ghana

## Background

Deeply rooted social stigma towards men who have sex with men (MSM) in Ghana affects their ability to access critical information and services for the care and prevention of HIV. In 2011, the Ghana Men's Study revealed a high prevalence of HIV (17.5%) among MSM at five sites in Ghana, with the highest rates in Greater Accra (34.4%) and the Ashanti region (13.6%) (Aberle-Grasse et al., 2013). The majority of study participants (>70%) were between the ages of 18-24, living at home and reported having no or low income. That study found that the prevalence of HIV was higher among older MSM (>35 years) and those with higher levels of income. The same study found that less than half (44.8%) of the surveyed MSM population had accessed HIV-prevention services in the previous year, and that 37% in Greater Accra and 23% in Kumasi had been reached by a peer educator. They also estimated a population of 30,579 MSM in Ghana.

Before 2012, the USAID/Ghana SHARPER Project employed conventional HIV-prevention outreach activities through MSM peer educators who were associated with community-based organisation (CBO) implementing partners in Ghana. The peer-education program was branded by MSM (as part of SHARP, the precursor to SHARPER) with a rainbow symbol and the tagline “It’s my turn” — to indicate that it was their right to be acknowledged, respected, and to have access to the same information and services as anyone else. Peer educators were selected by the CBOs for their leadership and communication skills, interest in HIV prevention and in supporting peers living with HIV, and their ability to complete short reports on completed work.

All peer educators were trained over a five-day period using a standard curriculum that focuses on communication skills, the role of the peer educator, HIV risk-reduction counseling, use of condoms and lubricant, management of sexually transmitted infections (STIs), HIV testing and counseling (HTC), illicit drug and alcohol use, mental health and self-esteem, gender-based violence, familiarity with key services, and learning to facilitate referrals. After training, peer educators are equipped with a toolkit to guide peer interactions between individuals and within groups. In light of the repressive environment, most interactions with peer educators are one-on-one. Outreach events are organised in a safe, discreet location, where from 20 to 50 MSM can take part in role-playing games and on-site HTC and STI services. These are known as “Love n’ Trust” events, which focus on the promotion of safer sex, routine HTC and STI screening, and partner HIV-status communication.

In addition, 11 MSM drop-in-centers (DICs) staffed by MSM leaders and part-time Ghana Health Service (GHS) nurses, offer HTC, STI screening and other health services. The SHARPER project also trained GHS nurses that were located in health facilities near “hot-spots” in key population-friendly service delivery to facilitate greater MSM access to public health care services. MSM can also use “Text Me, Flash Me, Call Me HelpLine” to speak anonymously (and free of charge) with a trained GHS nurse about their health, psychosocial concerns or gender-based violence. After providing counseling, the nurses make referrals to peer educators, DICs or GHS services based on the client’s wishes, and provide follow-up counseling where needed.

Peer educators and DIC staff assigned unique identifier codes to all MSM they reached (for the protection of their clients). National standardised monitoring forms are used to record key information about the clients and the counseling and services that were provided. Peer educators are supervised by peer leaders and CBO field supervisors. Peer educators meet once a week to plan their schedule; and they participate in monthly meetings to review challenges and successes, and to learn new or reinforce previously acquired skills.

Despite attempts by the CBOs to recruit peer educators that represented different MSM sub-groups, the majority were less than 25 years old. In 2012, peer educators reached more than 12,000 MSM, most between the ages of 15 and 24 years old (FHI 360, 2012). This amounted to less than 50% of the estimated number of MSM in Ghana (Aberle-Grasse et al., 2013). Peer educators and CBO staff members indicated that they were aware of other MSM networks — particularly those that were older or discreet about their sexuality, and who were not interested in being directly contacted by a peer educator.

Through discussions with MSM affiliated with the CBOs, SHARPER learned that social media were increasingly popular among MSM, and might be a new way to reach older or more discreet MSM who were not currently interacting with peer educators. The majority (88%) of the Ghanaian population uses mobile phones; 76% own their own mobile phone (CDD, 2012). There has also been a rapid expansion of social-media use in Ghana, especially Facebook, which is the most frequently used platform. In the United States, Europe, Latin American and Asia, social media have been increasingly used for communicating HIV-prevention information, promoting the use of HIV testing and counseling with MSM, and for recruiting and to a lesser extent retaining MSM in research studies (Ko et al., 2013; Sullivan et al., 2013; Young et al., 2013; and Young and Jaganath, 2013). Therefore, the SHARPER project piloted social media outreach among MSM with the aim of reaching sub-networks of MSM that were not being reached by peer educators. This case study describes this pilot and examines the resulting level of coverage of traditional peer education and social media outreach.

## Program Description

In early 2012, SHARPER canvassed its partner CBOs for recommendations of MSM leaders who might be at the center of MSM networks that included sub-group populations, such as older MSM, those who were more discreet about their sexuality, and others who might not be reached by peer educators. Three men who fit this profile were identified, one each in Accra, Kumasi and Tamale. These MSM were hired as community liaison officers (CLOs) to initiate social-media outreach activities in their respective communities. The CLOs recommended Facebook as the primary vehicle for reaching new networks of MSM, followed by Badoo, Whats App and Gay Romeo. The CLOs were supplied with a smart phone and a laptop computer and trained over the course of five days on HIV information and services – based on the same curriculum used to train peer educators. The CLOs were also trained how to count the MSM they reached and how to record monthly outputs.

The CLOs established new social media accounts and began to invite friends and contacts, while they conducted daily discussions on sex that interwove messages about HIV prevention, the use of condoms and lubricants, and routine HIV testing and STI screening. In addition, the CLOs operate a number of closed groups that discuss HIV, safer sex, sexuality, gender-based violence and psychosocial support needs. These groups are segmented by age and interests. The CLOs would also conduct private on-line and telephone conversations with MSM who requested more information or who were seeking referrals. In some cases, the CLOs physically accompanied their social-media contacts to the recommended services.

The CLOs also conducted outreach in bars, parties and other venues where their network congregated. In this way, they were able to increase their social-media contacts and to reach peers with information and referrals as needed. Peer educators rarely appeared at these venues, which typically attracted wealthier people.

The CLOs were recruited over different time periods; the one in Accra was hired first to test the original concept, learn from it, and then apply it to social-media outreach efforts in other locations. The CLO in Accra mentored and supported the CLOs in Kumasi and Tamale, explaining their roles and how to complete their monthly reports.

Project staff met with the CLOs every two weeks to review their progress, and once a month to discuss the CLOs' monthly outreach reports. The CLOs tracked the number of unique MSM that were reached. For the SHARPER project, an MSM is defined as "reached" if he received all of the following: a risk assessment, information on HIV prevention and a referral to HTC (or another HIV service). Each MSM was assigned a unique identifier code to facilitate the counting of reached individuals. We assessed for client overlap between peer education and social media outreach and found that 18% of MSM in Accra and 27% in Kumasi were also contacted by a peer educator in the past twelve months. We adjusted the number of MSM reached through social media by these proportions.

## Results from the pilot

2013, 15,440 unique MSM were reached through social media by three CLOs compared to 12,804 contacted by 110 peer educators. This amounted to 28,244 individual MSM reached which represented 92% of the estimated number of MSM in Ghana (FHI 360 2013). The majority of MSM reached through social media or by peer education were contacted two or more times during the reporting period.

Reporting data suggest that HTC service utilisation may have increased as a result of social media outreach. In Accra, more than 99% of MSM reached through social media

reported having accessed HTC in the past year. While only 64% of MSM reached by peer educators is the same period reported having been tested for HIV.

CLOs reported of high level of acceptability among MSM in their extended network of their on-line outreach. MSM found it to be a convenient and safe way of communicating about their sexual health needs and how to locate MSM-friendly services.

In addition, the CLOs report being sought by staff from MSM CBOs and others working with MSM in Ghana to advise them on their outreach strategies, and how to better utilise social media and tap into new networks of MSM needing access to HIV prevention and care information and services.

## Discussion

This pilot study underscores the value of social media in reaching new networks of MSM in Ghana, and using a more diverse approach to reach MSM with HIV-prevention interventions. Studies in the United States, Europe, and Asia that compared internet-based and face-to-face approaches to recruit MSM for HIV-prevention interventions, research, or surveillance concluded that internet-based approaches not only tended to reach new networks of MSM, they also reach higher risk sub-populations (Evans, Wiggins, Mercer, Bolding, & Elford, 2007; Fernández et al., 2004; Tsui & Lau, 2010; Guo et al., 2011; Khosropour et al 2014; Sanchez, Smith, Denson, Dinunno, & Lansky, 2012).

There were a few important challenges experienced during implementation of the pilot. The first was managing accurate enumeration of MSM reached through social media. During the first several months of the pilot, the CLOs and SHARPER team tested a number of different approaches to accurately measure unique contacts until a method was devised that was both sound and acceptable to the CLOs (as described in the program description). The second challenge involved the difficulty of verifying service utilisation among MSM contacted by the CLOs. Peer educators use carbon copy referral slips that are collected by implementing partners at service delivery sites once a month. With social media outreach, it was not possible for CLOs to provide MSM with referral slips, or to verify from the service provider that the service was accessed given the long list of public and private providers utilised by MSM across the three pilot cities. We were only able to collect self-reports as part of this pilot.

A number of questions need to be answered about the use of social media to reach MSM in Ghana. Formative research among MSM has touched on social media but more is needed to explore for which MSM sub-populations social media is most appropriate, types of information preferred and in what format, and frequency of use of different social media platforms (Sabin et al., 2013a; Sabin et al., 2013b).

We need to learn more about the risk behaviors of MSM contacted through the social media intervention, and whether they are at greater risk of HIV than MSM who are typically reached through peer education. We also need to determine the relative effects of social-media outreach and peer-education efforts on changes in HIV-prevention behavior and knowledge, including the use of condoms and lubricants, and the use of HTC and STI screening. In the United States, social-media outreach among MSM was associated with reductions in reported sexual risk-taking and an increased uptake of HIV testing (Ko et al., 2013; Young et al., 2013; Young and Jaganath, 2013).

Also, there may be ways to enhance the depth and quality of the social-media outreach experience. For example, more structured on-line HIV prevention “events” such as brief stories or case studies, video shorts or games could focus on generating discussion that may be more engaging to social media contacts (Jaganath et al 2012).

MSM social media contacts could also interact with scenario-based applications where as avatars they navigate real-life challenges to HIV prevention (Christensen et al., 2013).

Facebook offers an opportunity to post advertisements for HTC. In the US, the Centers for Disease Control and Prevention (CDC) “Testing Makes us Stronger Campaign” is an excellent example of using social media to promote HTC uptake among MSM (CDC ND). We also need to identify ways to track referrals made through social media to HTC including the use of e-vouchers.

## Conclusion

Social media is a very important avenue for reaching MSM not traditionally accessed by peer educators in Ghana and should be adopted as an integral outreach approach for HIV prevention interventions moving forward.

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## Biographical Statements

**Kimberly Green** is Chief of Party, [Strengthening HIV/AIDS Response Partnership with Evidenced-Based Results \(SHARPER\)](#), FHI 360 Ghana, has more than twenty years of experience in public health management, policy development and research. She specializes in HIV prevention and care systems and policy development, working with key populations, mHealth/ICT, ART adherence and retention in care, palliative care, and health intervention implementation and evaluation. She is the author of several technical reports, articles, training curricula and presentations and has provided technical assistance in more than 15 countries in Asia and Africa.

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**Samuel Wambugu** has 14 years of experience in project management, monitoring and evaluation, surveillance and research of public health programs in Africa. He is currently the Deputy Chief of Party of SHARPER project in Ghana, a USAID funded HIV prevention project implemented, with special interest in the use of technology to improve access and utilization of health services among underserved populations by FHI360. He has worked in several projects across Africa

**Philippe Girault** is an epidemiologist and public health expert working on key populations, particularly MSM, programming and research. Over the past 24 years, he has provided technical assistance to MSM programs in more than 12 countries in Asia and two countries in Africa. He has also conducted biological and behavioral surveys and research studies and published in peer-reviewed journals.

**Nana Fosua Clement** is a social development management professional with 16 years' experience in HIV programming for Key Populations, strategic behavior change communication, project implementation/management and research. She is currently the Associate Director, Technical of SHARPER Project in Ghana, a USAID funded HIV prevention project implemented by FHI360 with working experience in 8 African countries.

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