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Empowering Peer Outreach Workers in an HIV Prevention and Care Program for Kenyan Gay, Bisexual, and Other Men who have Sex with Men: Challenges and Opportunities in the *Anza Mapema Study*

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incidence in Kisumu, Kenya. He has lead studies of and implementation programs for MMC among men, women and providers in Uganda, Malawi, Zambia, Kenya and the Dominican Republic. He initiated the formation of the first support group for LGBTQ in western Kenya, called Kisumu Initiative for Positive Empowerment (KIPE), and has been the P.I. or co-investigator on numerous studies and prevention programs for MSM over the last 10 years. Bailey has trained PhD, MPH and MS students from the U.S., Kenya, Zambia and other countries and served as technical advisor and consultant to the World Health Organization, UNAIDS, the Bill and Melinda Gates Foundation, USAID, OGAC, CDC, the Kenyan MoH and The Centre for HIV and AIDS Prevention Studies in South Africa, and he has served on the advisory boards of various clinical trials and implementation programs. *Susan Graham*, is an Associate Professor of Global Health and Medicine and an Adjunct Associate Professor of Epidemiology at the University of Washington. She currently holds the Robert W. Anderson Endowed Chair in Medicine and is Associate Chair for Academic Programs in Global Health. Her research focuses on developing effective interventions to support HIV prevention and improve HIV care outcomes in vulnerable populations, including men who have sex with men and male and female sex workers, in Kenya and the United States.

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Gay, bisexual, and other men who have sex with men (MSM) are at high risk for human immunodeficiency virus (HIV) infection. In rights-constrained settings with pervasive stigma, peer outreach workers play a key role in recruitment and retention of MSM in HIV research, prevention, and treatment programs. We explored factors affecting the empowerment of peers in an HIV prevention and care study for MSM in Kisumu, Kenya, with the goal of improving program services and supporting good participatory practice. The *Anza Mapema* study, conducted from 8/2015-10/2017, aimed to enroll 700 MSM in a comprehensive package of find, test, link and retain in HIV prevention and care interventions, with quarterly follow-up over 12 months. Seventeen mostly heterosexual salaried staff implemented the clinical and research components of the study, while 13 gay and bisexual peers facilitated recruitment, retention, and participant education, supported by a monthly stipend. A community advisory board provided feedback on program methods and performance. In-depth interviews with peers and staff at two timepoints were used to obtain feedback and make program improvements. Thematic analysis was conducted, and results were presented to peers and staff for discussion and triangulation. Despite mutual appreciation of peers' contributions to the project, peers and staff had different goals and vision for *Anza Mapema*. While staff focused on implementing the study protocol, peers envisioned broader programming including community-building activities, advocacy, mental health and substance use services, and economic empowerment. From the outset, power disparities and power struggles between peers and staff favored the staff, as peers were younger, less educated, and had lower compensation for their time. While peers appreciated the opportunity to help their community and the free health services provided by the project, they voiced concerns about stigmatizing attitudes from some staff, insufficient training, exclusion from decision-making, minimal representation on the study team, and lack of opportunities for advancement. Staff were supportive of peer's requests but felt constrained by limited funding and rigid study timelines. Peers' concerns were addressed at least in part through monthly team meetings with program leadership, weekly meetings with outreach coordinators, additional training, the promotion of one peer to a salaried position, and the development of community-building activities and a support group for participants who struggled with alcohol and drugs. Integration of gay and bisexual peers into HIV research and programming is critical in rights-constrained settings but challenged by disparities in power between peers and staff. Empowerment of peers is an important component of good participatory practice, and requires attention to training, inclusion in decision-making, opportunities for advancement, and support for community-building. Future studies that rely on peers for participant recruitment and retention should address these issues and make peer empowerment an overt component of the program.

Introduction

HIV prevention and care research focused on gay, bisexual, and other men who have sex with men (MSM) is especially challenging in countries like Kenya, where same-sex sexual relations are criminalized [1, 2]. MSM are vulnerable to HIV due to the high risk of transmission during anal intercourse and as a result of structural factors that impede access to prevention and care, including criminalization, societal stigma, discrimination, violence, and exclusion from education and employment opportunities [3]. Good participatory practice guidelines for biomedical HIV prevention trials were written to prevent the replication of existing societal injustices and power inequalities in research studies and ensure equitable partnership with and input from communities and individuals affected by HIV, in order to assure that studies are carried out with scientific and ethical integrity. The *Respect, Protect, Fulfill* guidelines provide additional information and tools for researchers and members of the gay and bisexual community to form sustainable collaborations during all phases of research and ensure that studies are relevant to community needs [4].

In settings where MSM remain hidden and hiring openly gay or bisexual local staff is difficult, peer outreach workers (hereafter, 'peers') serve as crucial links between researchers, healthcare workers, and MSM in need of information and HIV prevention and care [5, 6]. Both good participatory practice and the *Respect, Protect, Fulfill* guidelines support the integration of peers, who are community stakeholders and representatives of study participants, as full partners into HIV prevention and care research. This is done both because it is "the right thing to do" and because direct engagement of peers facilitates participant recruitment and retention. Community-based participatory research similarly supports the full and equitable integration of community participants into all phases of research with the goal of learning together, decreasing inequalities, and achieving positive social change [7, 8].

Few studies have explored challenges to the empowerment of gay and bisexual peers working to improve the health of their communities in rights- and resource-constrained settings. This information could be uniquely valuable to practitioners of community psychology, as well as to clinicians, public health and social science researchers, and policymakers who are interested in community-based participatory methods and would like to learn more about empowering and improving health outcomes of sexual minority individuals and members of other marginalized communities.

We explored successes and opportunities for improvement in the collaboration between peers and full-time staff involved in a two-year HIV prevention and treatment study called *Anza Mapema* (Kiswahili for "start early") in Kisumu, Kenya. Our goal was to empower peers, improve program services and achieve good participatory practice, identifying lessons learned that could inform similar research and programs for MSM in rights-constrained settings such as Kenya.

Methods

Study context

The *Anza Mapema* study aimed to enroll 700 MSM in a comprehensive package of HIV prevention and care interventions, with quarterly follow-up over 12 months. Between 8/2015 and 10/2017, 636 HIV-negative and 75 HIV-positive MSM enrolled in the study, which was funded by the U.S. Centers for Disease Control and Prevention and implemented by the Nyanza Reproductive Health Society (NRHS) in Kisumu, Kenya [9]. Kisumu is Kenya's third largest city and has a sizeable MSM population, a relatively tolerant political climate, and a robust presence of gay and bisexual community organizations, led by the Nyanza, Rift Valley, and Western Kenya

(NYARWEK) coalition, which integrates the views of organizations it represents to empower them and advocate for health and socioeconomic well-being of the Lesbian, Gay, Bisexual, Transgender, and Queer community. NRHS had previously conducted a respondent-driven sampling study of MSM in the local community [10], and supported an initiative called KIPE (the Kenya Initiative for Positive Empowerment) to promote empowerment for the gay and bisexual community; KIPE's funding ended in 2013. Prior to study initiation, the *Anza Mapema* investigators met with gay and bisexual community stakeholders, law enforcement, religious leaders, and local HIV clinicians, to explain the aims of the study and address any questions and concerns. A community advisory board that included the Executive Director of NYARWEK, a representative of local law enforcement, a lawyer, and a religious leader was formed to oversee the study.

Study staff including two clinicians, a nurse, several counselors, two data managers, four outreach coordinators, and two project administrators were hired locally, with preference to staff with interest in and experience working with gay, bisexul, and more hidden MSM. One female staff identified as lesbian and one male staff as bisexual, while all others identified as heterosexual. All staff received evidence-based sensitivity training on male sexual health [11]. Eighteen peers worked with the project at some point during implementation. All peers identified as gay or bisexual. Peers received training about study procedures and on prevention and treatment of HIV and other sexually transmitted infections. A sub-group of HIV-positive peers receivied additional training about how to promote HIV treatment adherence by providing information (teaching), empathy (listening) and encouragement (coaching) [12]. Both staff and peers received human subjects protection training and certification, with an emphasis on confidentiality. All program staff were salaried and worked full-time. Peers were volunteers and received a monthly stipend to offset expenses of transportation and phone calls to study participants, as well as paid transport and meals during trainings.

Data collection

A semi-structured, open-ended topic guide was developed that explored experiences with participant recruitment and retention, program service delivery, work environment, and suggestions for program improvement, as part of a comprehensive mid-way evaluation of the program. Interviews lasting ≈60 minutes each were conducted in English or Dholuo with translation into English during June and July 2016. Notes were taken to supplement digital recordings.

Data analysis

Both interview notes and transcripts were analyzed. A coding dictionary was developed based on themes included in the interview guide and those that emerged from the data, including themes related to the good participatory practice and *Respect, Protect, Fulfill* guidelines framework (peer's concerns and priorities, perceived factors affecting peer empowerment and integration on the research team) and study outcomes (perceived factors affecting recruitment and retention) [13]. Transcripts were coded independently by two team members (DK and LQ), and discrepancies were resolved through discussion. Inductive analysis was used to describe common and outlying responses, as well as the broader relationship between themes [14]. Preliminary results were presented to staff in 7/2016 and to peers in 2/2017, then refined based on feedback. Direct quotes illustrating emergent themes were extracted for presentation.

Ethics statement

Study procedures were approved by the ethics review boards at Maseno University,

the University of Illinois at Chicago, and the University of Washington. All participants in this qualitative study provided written informed consent and received 500 Kenyan shillings (≈$5) to compensate for their time.

Results

Characteristics of peers and study staff

Seventeen of twenty-four current and former local staff were interviewed, including both staff members who did not identify as heterosexual. Thirteen of fifteen current and one of three former peers were interviewed. Staff had 0-13 years of experience working in HIV prevention and care, and 0-10 years in programs focused on MSM. Peers had 4-6 years of experience working in HIV prevention and 3-5 years in programs for MSM. Staff were in their late 20s to late 30s, while all peers were in their early to mid-20s except one who was 42. All staff identified as Christian, as did all peers except one who was Muslim. Most staff had a diploma or bachelor's degree and all were employed full-time. Most peers had completed secondary school and were either unemployed or did not have a stable job.

Emergent themes

Overall, themes that emerged included appreciation by peers and by staff of peers' role in the project, differing goals and vision for the project, power disparities and power struggles related to project implementation, and the need for ongoing work to address peer concerns and empower them.

Appreciation of peers' project role. Peers were appreciative of the opportunity to help their community, the free health services provided, and of study staff.

> *"There is no other organization that is doing what Anza Mapema is doing. They received a lot of people from our community. When they get sick they get their medications here for free. They get condoms and lubricants. On Sunday, they come to church here, a person preach for us. I really appreciate Anza Mapema, they taught us a lot of things, like interacting with people in the community to remove stigma an discrimination."* – Peer

> *"There are so many risks to being an MSM, like STI/HIV, so I wanted to learn more for my health. This was the right place for me because, this place, it is MSM friendly. Another reason is to see myself being free, while for other MSM coming out is so difficult. Even though here the staff are not LGBT you feel free because they know how to handle MSM and bisexuals."* – Peer

> *"Being a peer outreach worker motivated me, I have helped people to come access services, I am happy to be helping many people."* – Peer

Staff praised individual peers for their hard work and dedication and were appreciative of the positive impact that peers' input had on the project.

> *"Peers teach participants about HIV, STI symptoms and signs. Some bring people for treatment of anal warts and gonorrhea. They promote HIV testing, do condom demonstrations and distribution. Those who are from MAAYGO* [a local gay and bisexual men's organization] *see their participants constantly. Others only see them for peer led group meetings. Some peers bring 7 participants, others 27. A few are very good."* – Staff

> *"I like the peers because they get to speak their mind, and also they get to let you know what the participants think, what the participants want… we are able to see what happens behind the study, and this makes the study*

> *better."* – Staff

Differing goals and vision. At the same time, peers and staff had different goals for *Anza Mapema*. Peers wanted the project to be a space for community-building activities, advocacy for LGBTQ rights, training about health and job skills, and opportunities for enconomic empowerment, and were dissapointed when their vision, related in part to past activities by KIPE, did not materialize.

> *"When the study was started, we were promised so much. Promised trainings, now there are none. Before, there were coffee Wednesdays, movie Mondays, dancing club, now only the health talk and Sunday church."* – Peer

> *"The previous project KIPE seemed to have lots of activities supported financially as opposed to this other one. Peers and participants draw comparisons between what happened before and now."* – Staff

Staff generally discussed the project goals in the narrow sense of HIV prevention and care, and the need to achieve established targets for recruitment and retention. A few staff felt that the research aspect of the program took up too much of their time, at the expense of building relationships with peers and the gay and bisexual community.

> *"I think we need to have more inclusion and more partnerships with the LGBT community. I think we sort of got into research mode, we were thinking of the Outreach Department as the group who should be doing projects while we would be doing research work."* – Staff

Staff mostly discussed peers in the context of recruitment and retention, and not in a broader sense of collaborative effort to improve health or welfare of gay and bisexual men. Because most staff were busy with the research side of the project, peers usually only interacted with outreach coordinators, project administrators, and the receptionist, but not other staff.

> *"The clinicians and nurses have helped me know my status and ways to maintain the negative status. I have not been close to clinicians and nurses, so I do not know much about them."* – Peer

Even after working for a year on the project, some staff still had stigmatizing attitudes and misconceptions about MSM. Some were aware of this and requested additional training.

> *"Generally Kisumu is an MSM-friendly town, and the MSMs just need to be told that their behavior, the way they behave our there can affect their security. This takes us back to that being an MSM is a choice, when you make that choice, you need to know that it should not be bad. I do not need to act out because I am straight, neither do I need to act out because I am MSM, just be MSM and let people be comfortable."* – Staff

> *"Sometimes they hang out here and staff say, why are these people here, it is not their visit today. In another program, I know there was a drop in center. No one would ask them what they were doing."* – Staff

> *"Trainings for staff about LGBT other than the MARPs sensitivity training would be helpful for me to learn how to handle LGBT better."* – Staff

Other staff, including those who had worked with gay and bisexual men for years, described how they initially had stigma against them and changed their mind after connecting with the peers and study participants.

"They are like my sisters and brothers, they want to be accepted. I have to be motivated coming to work, as this is my source of income. This work makes me have more hospitality. I was brought up in Christian society. At first I thought: "Ah! This is against my religion!" I changed my mind after encountering them and seeing what they go through." – Staff

"*Actually, my first encounter and experience with MSM, I was traumatized, I could not understand men having sex with men. But then I accepted them. Initially I was rooted in my own values, but having to work with them, I learned that they just normal as any other people. For you to help them, their medical health, and even mentor them, you need to accept people the way they are."* – Staff

Power disparities and power struggles. There were tensions between peers and project administrators over pay. As most peers were young, had a low education level, and were either unemployed or working temporary jobs, many regarded their volunteer stipend as a salary and complained that it was insufficient.

"Most of these people don't have jobs and are poor. It's also the case with peers, they tend to see it as employment, not as volunteering, when stipend is reduced it becomes an issue. The 4500 KSh is a stipend to thank them for work, 500 Ksh for airtime, the rest to help facilitate their work including transport. They take 4500 as salary and say it is not enough." – Staff

"*Stipends are so little. There's so much work… They say use 500 KSh to look for new clients, 500 KSh for tracing, 500 KSh for airtime, 500 KSh for follow-up. It is like a favor, what we are doing."* – Staff

"You come here in the morning, they say you have to go look for a client, you have no time to do work elsewhere." – Staff

Staff spoke in glowing terms about some peers whom they perceived to be hard-working and effective in recruitment, counseling, and retention. They also voiced concerns that some peers were inflating the frequency and quality of their follow-up.

"*A few are very good. Others are good mobilizers but semi-literate. The peer who says he meets with his 35 participants for 30-45 min face-to-face twice a month, this is not realistic. Sometimes they talk big to impress."* – Staff

Staff worried that some peers had misunderstood what follow-up entailed due to low literacy or limited training, and suggested additional training on follow-up procedures and reporting requirements.

"There should be a refresher training every six months. We found that they do not even know how to fill reporting tools, some can't calculate the number of condoms they distribute or know what face contact with the participant means. They should be trained on basic knowledge of HIV and STIs. They are good mobilizers but semi-illiterate and do not accept that." – Staff

"There are reporting tools, every month they are supposed to see their clients and fill out forms after distributing condoms and lubricants. It is not easy to fill these every month for 45 clients, so many are complaining." – Staff

Some staff thought that peers were not paid enough, while others, including administrators, thought the stipend was sufficient.

> *"They are not staff so we cannot pay them salaries. Instead, for their volunteering we provide them with resources for what they need to do, same way as we provide them with lubricants and condoms."* – Staff

Some peers worked to maximize the amount of reimbursement money they received, including by double enrolling participants into other ongoing studies in the area, as well as recruiting participants who were not sexually active with men. At the same time, some participants would not tell peers that they were already enrolled in another study or receiving HIV care elsewhere, and some straight men who struggled with poverty pretended to be gay or bisexual to receive reimbursement money. All this contributed to tensions between peers and staff.

> *"Some peers work for LVCT, NYARWEK, and refer participants to several programs. Some MSM take drugs at multiple facilities. There is double entry, double the medication, wrong data."* – Staff

Although staff provided additional funds for tracing on a case-by-case basis, they worried that peers would sometimes pocket this money, make insufficient efforts, or recruit men who were really not eligible for the study.

> "*For some peers it is just about the money. We give one 300 Ksh to trace people, the next day he has come back. He has not brought the participants, cannot account for the money, then asks for more money to trace new participants. But not all peers are bad. For others, I can tell him, bring the person first, then you will be reimbursed."* – Staff

> "*Some of the peers are so hardworking and trustworthy, they bring genuine clients. Some of them are not really trustworthy. It took some time to let the peers know that it is wrong to coach clients. Maybe the targets they are given are making them to cheat. At the same time, there were many meetings to discuss how to make peers not cheat, to bring the correct clients, to feel not so much pressurized."* – Staff

With respect to increasing community-building activities, project administrators emphasized that the current focus was research and that only sustainable programming would be supported.

> "*Whatever we start, it has to be sustainable, because we do not have a big pot of money where we keep dishing money to go watch a movie, transport reimbursement to come to church, to come and say hi."* – Staff

Peer views focused on their struggle to have more power and ownership in *Anza Mapema*. As a result of not being involved in decision-making, and because it took months before their suggestions resulted in addition of community-building activities, many peers did not feel sufficiently integrated into the project.

> *"If someone is sick, STIs are treated for free. If someone is HIV-positive, there are free drugs. There is also transport back home that is free. There is free lunch. They are treating guys and putting them in care, making this place a Freezone for MSM. Anza Mapema is really trying but is not there. This is not an MSM-led organization. In other organizations, I can say what I want. Here peers feel afraid, they can't kiss, they fear judgment."* – Peer

Some of peers felt that they were not treated fairly by staff, promised things they were not given, or received insufficient training to do their job, then had their stipend amount cut when whey were unable to trace lost

participants.

> *"They promised a prize for the best performing peer and did not give it. The peers were not taken to the retreat. There should be an orientation about how to handle MSM. They're only straight guys working here, the training should motivate them."* – Peer

> *"They are trying to choose and favor certain peers. They don't tell you the time for your peer-led activity. Educators are supposed to be trained: there should be a refresher training to teach them how to do their work. Some of the peers do not know how to do their work. I get a small stipend and somebody with fewer clients gets more money."* – Peer

Some peers requested that more staff be hired from the gay and bisexual community to help them and their participants feel welcome and have more ownership of the project.

> *"Some MSM are still closeted. It would be helpful for them if one of the study staff was also MSM so that they could feel close to him and relate to him. The study coordinator is good and everyone likes him, but he is often busy and in meetings. It would be nice to have someone like him who is also an MSM and can talk to study participants anytime they have questions or problems or issues."* – Peer

Program administrators agreed with this, but struggled to find anyone who was openly gay or bisexual and had the required qualifications as clinician, counselor, community outreach coordinator, receptionist, quality assurance, despite multiple advertisements posted for these positions.

<u>Peer empowerment</u>. Despite differing visions for the program and persistent power disparities, both peers and staff felt their relationship during the study to have been constructive and positive overall. Turnover rate was moderate, with three counselors and three peers leaving *Anza Mapema* for projects with higher salary or other reimbursement. Staff and peers credited monthly meetings between staff and peers and more frequent one-on-one meetings with individual peers with helping resolve challenges and misunderstandings.

> *"Some of the staffs were not friendly to the MSM community, they took it as a different thing they did not know before, but I think through holding staff meetings they reached and understanding, they improved."*- Peer

> *"There was a challenge in retention. At one point many did not turn out for month three. Since then the peers have turned out strongly. They* [the project administrators] *met with the peers. They said that participants should not be lost to follow-up and created that database for peers, and for anybody who has more than 40 participants that they are in charge of, these participants should be redistributed to peers who have less than 20 participants. He has advised the peer coordinators to improve their supervisory skills. This has worked well."* – Staff

Peers suggested additional sensitivity training for staff about how to work with gay and bisexual men and suggested joint events to help staff and peers get to know each other better.

> "*Clinicians and counselors are very friendly and cooperative. There are some people here, we call them putting on a sheep's wool, they just want money so they say they are willing to work with gay. Peers should sit down one on one so they can ask questions,*

anything they do not understand. They do not see the challenges that peers raised. You can do a retreat, maybe call for a day meeting, because you cannot work when you cannot understand people, you only see them as gay." – Peer

Some staff had suggestions for how to empower peers:

"In the past, everything was left to participants and peers to bring food and receipts, to appoint themselves, to educate one another. If you take all these responsibilities from our peers and the participants, they will not get a chance. You should leave it to them. They should be allowed to organize themselves, if they have a problem they bring to us. But anything else, money, what, let them organize themselves," – Staff

The peer stipend was eventually tied to demonstrated ability to recruit and retain participants, which most peers found to be fair. Those who were struggling requested additional training.

"We changed the contract so that the stipend is not fixed and just tied additional money to being able to bring the participants and trace them. Because it is not fair and demoralizing to pay the same to those who do more work. It is hard to get people to be consistent. Some are on and off." – Staff

"*They say they will look to see what is wrong…they tell us we are not working well. My clients are always coming but some relocated, some are busy at their work, and some changed their phone numbers. A training would boost me on my peer education to learn more."* – Peer

Some staff were acutely aware that peers wanted and needed to be more involved in project programming. At the same time, they also realized that peers would not take up additional responsibilities without additional pay, which was not available in the project budget.

"We need to have the gay community to be incorporated into the activities as one or two staff. They have this saying"Nothing for us without us." We have staff, none of them counts as MSM, it creates a lot of suspicion, one day they may decide, this is not a place for us, you do not recognize us," – Staff

A few peers requested full-time employment or vocational training to help obtain a stable job outside of the project. Several staff were supportive, including of hiring peers to improve engagement of peers and study participants in *Anza Mapema*.

"*Besides reimbursement, we should have a long term plan to equip some of them with knowledge, some are learned. If we have job opportunities in the future, a few are graduates who can be helpful. We can recruit them. This will provide them with a stable income and this will help us retain participants."* – Staff

Feedback, triangulation, and resulting program change

Preliminary results from this study were presented to *Anza Mapema* staff and peers in 7/2016 and 2/2017, respectively, to ensure the accuracy of findings and discuss how to improve the program. Based on recommendations from peers and staff, additional peer trainings we conducted on counseling for behavior change and HIV prevention. Importantly, one of the peers was formally hired to help provide supervision and serve as peer advocate. As a result of peer requests, Movie Monday and a support group

for drug and alcohol abuse were added to improve community-building and support participant ownership of the clinic space. In March 2017, peers and staff cooked and shared a meal and came together at another event to discuss concerns and answer each other's questions. Follow-up in the *Anza Mapema* research project ended in 10/2017, and a pre-exposure prophylaxis (PrEP) study has since been completed. Currently, programmatic services for HIV prevention and care are ongoing.

Discussion

This study is the first to describe challenges faced by peers and staff in building a collaborative relationship and supporting good participatory practice in a research project investigating an HIV prevention and care intervention for MSM in an African setting. *Anza Mapema* successfully enrolled its [7] and achieved retention of over 80% at one year. Despite staff working hard to create a supportive environment for participants, and peers valuing project services and the opportunity to help their community, we fell short of engaging peers as full partners and overcoming existing power inequalities between peers and staff. This was in part due to differences in goals and vision for the program and in part due to *Anza Mapema* structure and context as a research project with limited funding.

Some peers and staff suggested that peers would benefit from more comprehensive and ongoing education, training, and supervision. They also felt strongly that peers should be empowered by being given an equal seat at the table, through better compensation and mentorship, to make a meaningful contribution to *Anza Mapema* program design and implementation, start on a path to a career, and advocate for their community. While these are all in line with good participatory practice principles and had support of the project leadership, they could not be fully implemented due to pressures to conform to the research timeline and budget constraints. While both peers and staff advocated for hiring more gay and bisexual staff, none applied who had the required qualifications, likely at least in part due to structural barriers to educational and work opportunities for openly gay and bisexual men.

Funding for many research studies that recruit MSM in Kenya contrasts sharply with the poverty and lack of advancement opportunities for peers and participants who make these studies possible. This problem has frequently perpetuated existing power inequities and inadvertently created incentives for participant double-enrollment, as well as for straight men who similarly struggle with poverty to pose as MSM to receive study reimbursement. Despite representation of gay and bisexual community and advocacy organizations on the *Anza Mapema* community advisory board, the peers' vision of a program focused on community empowerment and advocacy was not attained because the priority of the program was HIV prevention and care research.

Community-based participatory research encompasses a spectrum from outreach and consultation with the community to collaboration and ultimately shared leadership, where community members participate fully and are invested in both research and program design, which are concordant with community goals [15]. Such an approach could overcome some of the challenges we faced in *Anza Mapema*. For example, when Black MSM were part of the leadership team starting in the planning stages of an HIV prevention study in the United States, they were able to suggest qualified black MSM candidates for staff positions overseeing participant retention, recruitment, and study implementation in a way that reflected community needs and values, incorporating support for employment, education, and empowerment

into their work [16].

Our findings reflect themes that emerge clearly from other HIV prevention and care studies that have depended on peer educators for MSM participant recruitment and retention, regardless of country setting [17-19]. In South Africa, peer volunteers recruited to help with an HIV prevention program for MSM in black townships received basic training about peer responsibilities and had opportunities to contribute to program design. As in *Anza Mapema*, peers were less interested in research processes and outcomes and more interested learning how to advocate effectively for their community. They asked for additional training in community advocacy and raising awareness about human rights, becoming role models to their peers, and how to build relationships with peers who were more closeted or for whom trust was an issue. [17]. In an HIV prevention program in El Salvador, salaried peer educators struggled with participant recruitment in a society characterized by widespread stigma, gang violence, and mistrust of the healthcare system by gay and bisexual men, and advocated for economic and educational empowerment of participants to improve retention [18]. In the Unites States, salaried or volunteer peers in the *Young MSM of Color NPNS Initiative* were tasked with recruitment, linkage, and retention of young minority gay and bisexual men living with HIV infection. Like *Anza Mapema* peers, these peers were young, of a low education level and limited work experience compared to program staff. As in *Anza Mapema*, they similarly struggled with feeling overworked, underpaid, not sufficiently trained, and not being asked for input about program decisions. Staff similarly advocated for close supervision, full-time employment, and mentorship as possible solutions [19].

Our findings also mirror challenges highlighted in the Research Engagement document put together by G10, the research advisory committee hosted within the Gay and Lesbian Coalition of Kenya: the lack of sustained partnership between many researchers and the gay and bisexual communities they work in, lack of shared research objectives, insufficient research training and literacy among gay and bisexual men, lack of durable partnerships within the community due to diverse interests, and lack of appreciation among researchers about how a full partnership with peers and the larger lesbian, gay, queer, and trans-sexual community has the potential to result in research that is more relevant and of better quality [20]. Although *Anza Mapema* researchers have sustained relationships with local lesbian, gay, queer, and trans-sexual organizations and are eager to incorporate suggestions from the community, funding for their efforts is often limited to research on biomedical outcomes and is time-limited, hampering the long-term goals and objectives of reducing community risk. HIV biomedical research studies in vulnerable and economically disadvantaged communities have recently included funding for community-building activities and community empowerment as part of good participatory practice, as well as program evaluation using qualitative research methods with the goal of explaining the reasons for successes and failures to assist with scale-up and adoption in different contexts [21]. Based on our findings, we fully support this approach. Moreover, we are currently taking a community-based participatory approach to the development of a new PrEP and sexual health intervention (funded by NIH grant R34MH118950), in collaboration with NYARWEK.

This study had several limitations. First, interviews were conducted by an English-speaking investigator who was not Kenyan, with Dholuo translation provided by a research assistant in four peer interviews. Neither of research these team members identified as gay or bisexual. This may have led to biased or incomplete responses.

Second, these results capture a point in time for the *Anza Mapema* project, and may not reflect all ongoing challenges. Third, these results reflect work at a specific research project in Kisumu, Kenya, and may not apply to other geographic and cultural settings. Although some results may have limited generalizability, the congruence of our findings with those of similar studies employing young gay and bisexual peers from vulnerable communities is striking. Strengths of the study include an open approach to identifying challenges, in which all interviewees were encouraged to be honest and assured of confidentiality. Results were presented to and discussed with both staff and peers, who felt them to be an accurate representation of their views.

Conclusions

Despite a higher prevalence of HIV among MSM in Kenya and East Africa compared to the general population, there is a lack of programming prioritized for this marginalized and vulnerable population. Our study is the first to describe challenges with empowering peers to be full partners in an HIV prevention and care research project for gay, bisexual, and other MSM in an African setting. Peer research team members in resource-constrained settings need to be empowered to make their voices heard, through education about research and good participatory practices that takes into account their youth, their health literacy, and their limited educational and career opportunities. Staff should similarly receive education about the importance of good participatory practice and full engagement of peers, to ensure the scientific and ethical intergrity of the study. Study protocols should include specific goals and metrics, numeric and qualtative, related to peer empowerment, and study budgets, staffing, and timelines should allow for implementation of a common vision. Peers need adequate compensation and resources to do their work, ongoing mentorship and supervision, and frequent discussions to facilitate work to achieve agreed-upon common goals and not just the goals of the researchers. These may include advocacy for gay and bisexual rights and economic empowerment through continuing education and job training. Ultimately, more providers and researchers from the gay and bisexual community are needed to advocate for and mentor others and to create greater trust and a truly shared research agenda. Our findings may be informative for other projects that aim to improve health for gay, bisexual, and more hidden men who have sex with men in other resource- and rights-constrained settings.

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Competing interests

The authors have no conflicts of interest or commercial associations to declare.

Authors' contributions

SG and DK conceived the idea for the paper. DK and LA conducted interviews. DK and LQ coded data. DK wrote the first draft. SG, RB, SO, FO, LQ, and LA provided feedback and guidance for revisions. All authors reviewed and contributed to the final document.

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