KP-led COMMUNITY STRATEGIES for PREVENTION and TESTING services

EECA CRG platform webinar – 10th March 2023

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Content of this presentation

- The challenge ahead – Targets and coverage
- KP-led strategies to reach 95% - Global guidance
- KP-led strategies – Country Examples

The challenge ahead – Targets and coverage

The challenge ahead - Targets

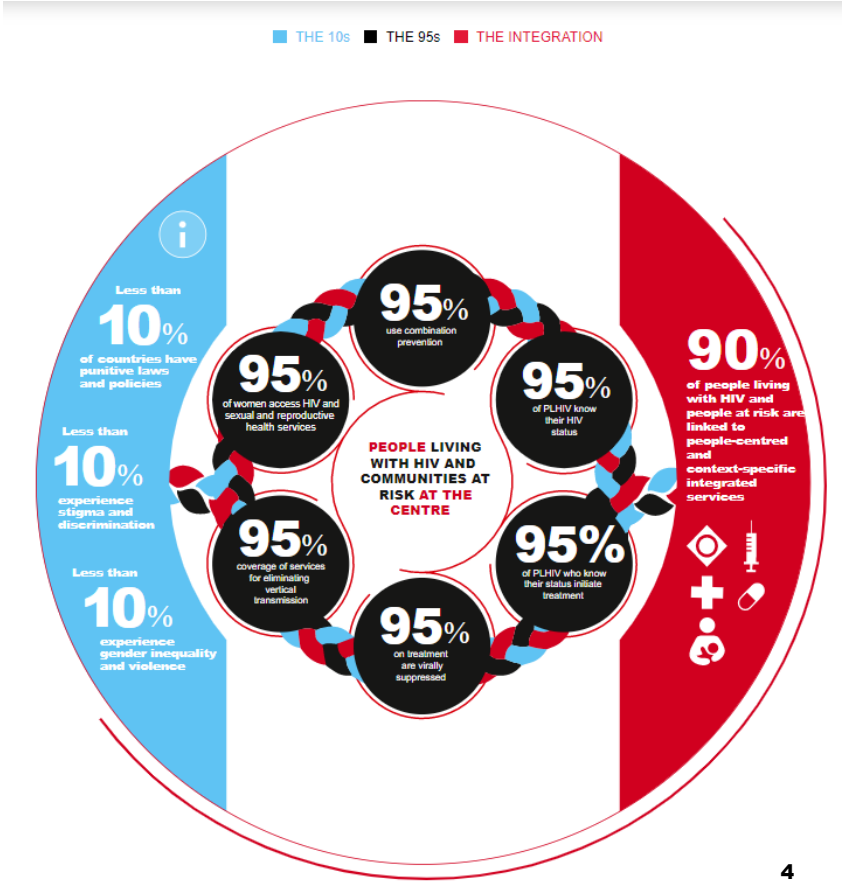
Global AIDS strategy includes Six 95s for comprehensive HIV services
Specific for Key Populations:

Prevention

- 95% of people at risk of HIV infection use appropriate, prioritized, person-centred and effective combination prevention options by 2025
- Key is frequency of access

Testing & Treatment:

- 95 – 95 - 95 testing and treatment targets achieved among people living with HIV within all subpopulations and age groups by 2025
- Job is getting harder – HIV testing strategies need differentiation



The challenge ahead – Coverage

- Set ambitious and realistic targets
- As much as possible use accurate and updated population size estimates
- Set targets for the frequency of outreach that correspond to the actual needs for effective delivery of HIV prevention and treatment services
- Targets should be aligned with the disaggregated targets in the Global AIDS Strategy, unless a compelling rationale for adopting different targets is presented.

1. Prioritization

Focus on Programming Essentials described in the Global Fund HIV Note (2022).

2. Targeting for scale, coverage and impact

Ambitious targets based on realistic and updated population size estimates (95-95-95 by 2025).

3. Meaningful engagement of key population communities in all aspects of the response

Communities are engaged as stakeholders at all levels – national to local – in program planning, implementation, and monitoring and evaluation.

KP-led Community strategies to reach 95% – Guidance

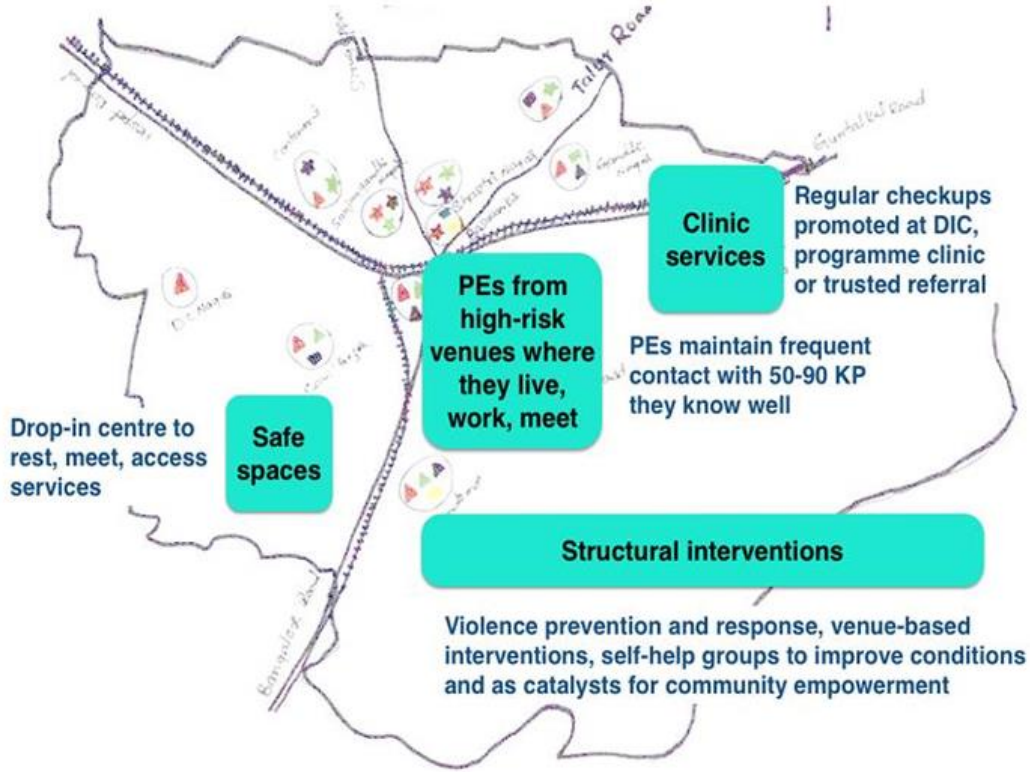
KP-Led community strategies to reach 95%

For PREVENTION AND HIV TESTING

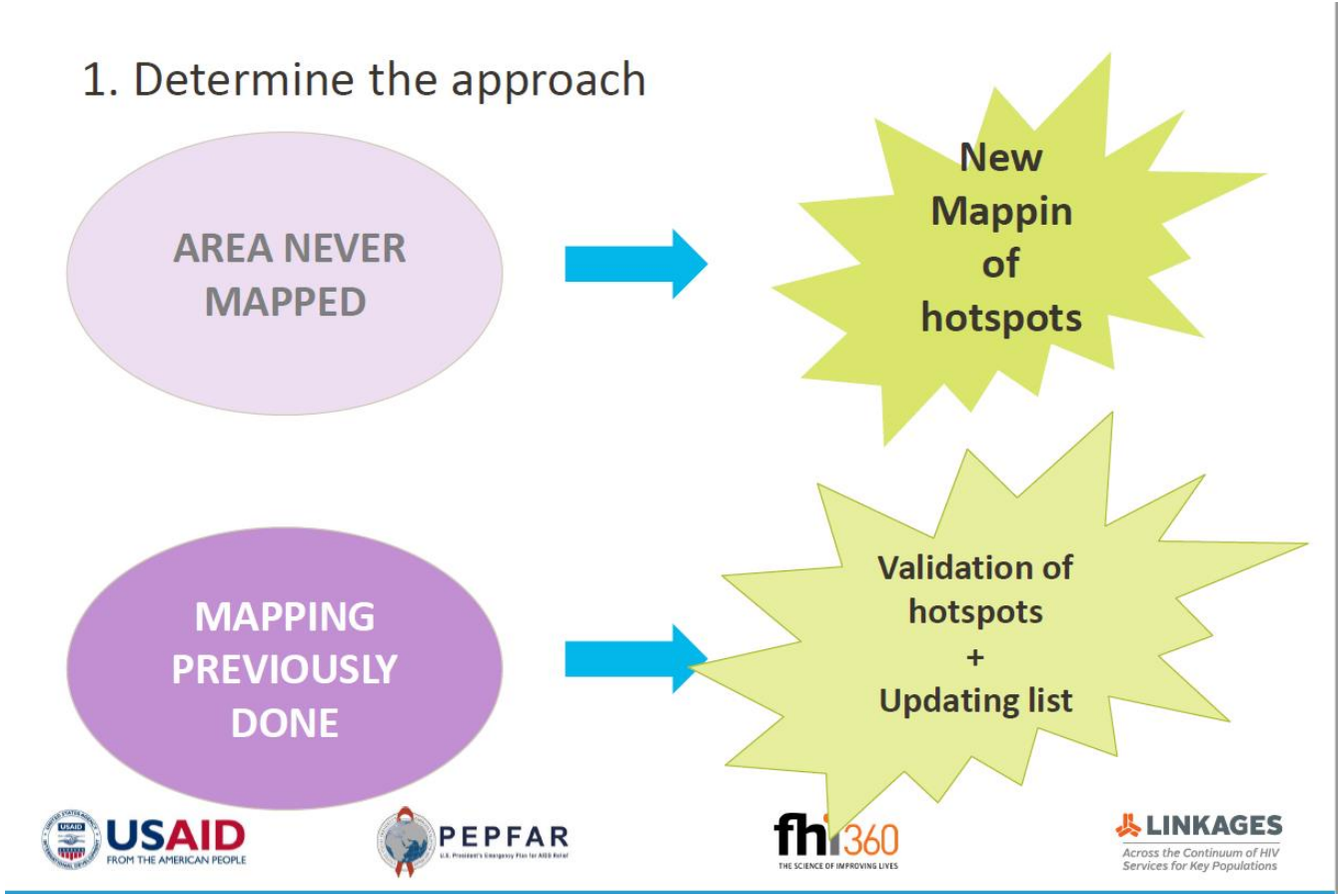
- CONTINUOUS COMMUNITY-LED OUTREACH PRESENCE IN HIGH-RISK VENUES via PROGRAMMATIC MAPPING
- DROP-IN CENTRES – SAFE SPACES
- KP FRIENDLY & TRUSTED CLINICAL SERVICES
- MOBILE CLINICS
- CLEAR AND FUNCTIONAL REFERRAL PATHWAYS COMMUNITY TO CLINICS
- STRUCTURAL INTERVENTIONS
- OUTREACH IN VIRTUAL SPACES

For HIV TESTING SPECIFICALLY:

- HIV SELF TESTING
- SOCIAL NETWORK TESTING
- PARTNER NOTIFICATION SERVICES



PROGRAMMATIC MAPPING



Trusted Access Platforms are critical

- 'Platform' = foundation on which effective Key Population programmes are built
- Also a way of working with key population communities to establish trust and improve access to those services
- Programmes may be implemented by Key Population led organizations or other civil society organization in partnership or with support from government - but derive their effectiveness mainly from **active key population engagement and participation**
- TAP at local level are building blocks for national programmes at scale
- Includes consideration for budgeting

The focus of this document is on the principles of building a solid foundation for key population service provision, one that enjoys high levels of trust and participation with and by key populations in community and clinic settings

Part 1: Intervention design for impact

1. **Engaging community with continuous key location presence**
2. Safe spaces
3. Structural interventions
4. **Strengthening outreach (including microplanning)**
5. Prevention basics (condom/lubricant, needle/syringe programming)
6. Optimising clinical services (regular medical checkups)
7. Boosting prevention and treatment cascades

Steps in implementing community led outreach

01

STEP 01 Map the community and design an outreach team structure

02

STEP 02 Recruit and train the outreach team

03

STEP 03 Conduct microplanning to implement, manage and monitor effective outreach

04

STEP 04 Foster leadership opportunities for outreach team

Key populations in virtual spaces

- Key populations have different needs and preferences for services. Some prefer to access information and services at a safe space and community center; some prefer to meet their peers at the venues and others prefer to receive information online in a discreet way
- Providing information and services to KPs who operate in virtual spaces has become essential
- **Information and services to KPs in virtual spaces can be provided through peer facilitation** or though technology mediation

Activities		Minimum		Basic		Full		Full + ART	
		Low	High	Low	High	Low	High	Low	High
Plan	Quick online surveys	●	●	●	●	●	●	●	●
	Social media mapping	●	●	●	●	●	●	●	●
	Density mapping	(Optional)							
	Community advisory groups		●		●		●		●
	Online audience segmentation		◑		◑		◑		◑
	Online audience estimation	◑	◑	◑	◑	◑	◑	◑	◑
Reach	Social network outreach	◑	●	◑	●	◑	●	◑	●
	Social profile outreach		●		●		●		●
	Social influencer outreach		●		●		●		●
Engage	Virtual case management					◑	●	◑	●
	Decentralized drug distribution (DDD)							◑	●
	Chatbots	(Optional)							
Improve	Online Reservation and Case Management App (ORA)	◑	●	◑	●	◑	●	◑	●
	Electronic client feedback system (LINK)	◑	●	◑	●	◑	●	◑	●
	Standard DHIS2 Tracker	(Optional)							

Renumeration

> Community outreach workers should always be remunerated for their work. However, certain approaches may be problematic: for example, paying community outreach workers for each individual they persuade to come to the clinic or drop-in centre for services can distort demand and lead to coercion. Less coercive and more effective incentives include phone credit, non-monetary gifts, leadership opportunities and recognition that is not linked to the number of sex workers who are brought to the programme.

Table 3.1 Remuneration of community outreach workers

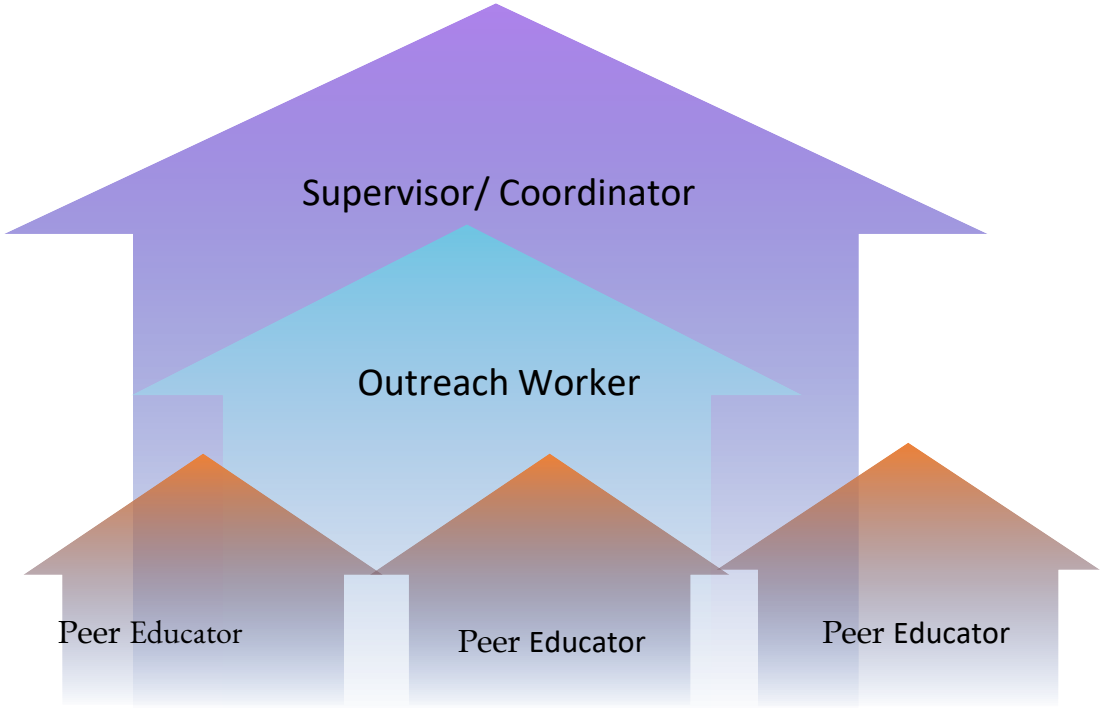
Resource spent by community outreach worker	Remuneration	Rationale
Time on outreach (includes time for travel, meeting with sex workers, reporting, planning further outreach)	Salary	Agree upon a rate that is acceptable to community outreach workers and feasible for programme sustainability. If possible, rates should be set consistently across state and national programmes.
Time on extra training	Stipend	Hours spent in training are lost work time, and programmes should recognize that community outreach workers have another job and personal obligations that cannot be fulfilled when they are in training.
Travelling between venues, for referrals, training, etc.	Bus, train, taxi charges, as required	It is usually most efficient to map travel routes and fix travel allowances for groups of community outreach workers depending on the requirements. They should be given travel stipends in advance on a routine basis (since most may not be able to pay first themselves and then wait for reimbursement).
Mobile phone airtime	Mobile phone airtime (predetermined is usually best)	Whether using text messages or limited talk time, community outreach workers should be remunerated for on-the-job phone use.

Fostering leadership

- Training and mentoring and opportunities to learn new skills
- Peer progression
- Opportunities for programme management and leadership roles
- Involvement in programme monitoring and planning

Peer Education strategies – Country Examples

Kenya - Outreach Team Structure



Renumeration of the Outreach Team

- Renumeration for the outreach team is also defined in the guidelines as follows:

1. FSW/MSM and Transgender programmes
   - Outreach Workers-10,000-12,000 Ksh
   - Peer Educators-3,500-4,500 Ksh
2. PWID Programmes
   - Outreach Workers-10,000-20,000 Ksh
   - Peer educators-3,500-4,500 Ksh

- This was set in the 2014 guidelines but through a TWG decision, the renumeration of peer educators was changed to 6000 Ksh – 7000 Ksh
- In additions, implementing organisations offer stipends for travel or airtime
- The country is planning to revise its national guidelines and hence the renumeration will be further revised

Capacity building

- Critical aspect of a KP programme
- Specific cadre wise training
  - Outreach team (peer educators, outreach workers, advocacy workers, paralegals)
  - Clinical team (clinician, counsellors, nurse
  - Programme management (Prevention officers, managers)
- Re-fresher trainings are also conducted for the outreach team
- TOTs are conducted by the national programme
- Capacity building plan is developed quarterly and certification done by the national programme

GHANA EXAMPLE ENGAGEMENT OF PEER EDUCATORS AND DEPLOYMENT OF MICROPLANNING APPROACH

Micro-planning tools used by peer educators include the following:

- Hotspot (microsite) maps
- Peer educator daily activity dairy
- Individual KP tracking tools
- Risk and vulnerability assessment tools
- Weekly outreach planning tools
- Monthly summary tools

After contractually engaging Peer educators, Sites are assigned for microplanning

"Micro-planning" is a process that decentralizes outreach management and planning to grassroots-level workers (outreach workers and peer educators) and allows them to make decisions on how to best reach the maximum number of community members.

It improves the effectiveness and coverage of peer led outreach efforts by allowing peer educators to transition from being passive data gatherers to active site managers who analyze data from their site and use it to plan and execute outreach.

Microsite: An ideal microsite should be concise geographical area that has one or more hotspots with between 30 to 60 enumerated KP, to which one peer educator (PE) will be assigned.

GHANA INCENTIVES SYSTEM (HONORARIUM)

Create a system of reinforcement of financial and non-financial incentives These incentives may include

T&T allowances, recognition, awards, social and recreational opportunities.

Examples include; Annual Awards for best peer educators, Quarterly cash prize motivation for top performer per quarter

Develop and implement a peer progression system that offers opportunity for interested PE and CM to move up the ladder, (volunteer status to staff, peer leader, supervisor and program officer etc.)

Resources

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Peer Education strategies to reach 95%

Interventions: Program Essentials & Prioritized Program Areas

HIV primary prevention (2.2.1)
HIV testing (2.2.2)
HIV treatment (2.2.3)
Elimination of vertical transmission (2.2.4)
TB/HIV coinfection (2.2.5)
HIV strategic information (2.2.6)
Human rights (2.2.7)

Included in the HIV Information Note and Key Population Technical Brief

+

Service Delivery Approaches

Community leadership (2.3.1)
Differentiated service delivery via trusted access platforms (2.3.2)
Virtual outreach and interventions (2.3.3)
Links with services for other diseases (2.3.4)

Included in the Key Population Technical Brief

Maximizing People-centered Integrated Systems For Health	• Scale, coverage & closing gaps (3.1.1) • Target setting (3.1.2) • National Strategic Plans (3.1.3) • Budgeting (3.1.4) • Sustainability (3.1.5) • Strategic Information (3.1.6) • Integrated, people-centered quality services (3.1.7)
Maximizing The Engagement & Leadership Of Most-affected Communities	• Stakeholder engagement in • Program planning and design (3.2.1) • Community systems • strengthening (3.2.2) • Advocacy & partnerships (3.2.3)
Maximizing Health Equity, Gender Equality & Human Rights	• Stigma, discrimination & violence (3.3.1) • Legal literacy and access to justice (3.2.2) • Law enforcement (3.3.3) • Laws, regulations & policies (3.3.4) • Harmful gender norms &GBV (3.3.5) • Community mobilization & advocacy (3.3.6)

Included in the Global Fund Strategy and Key Population Technical Brief

Technical Brief

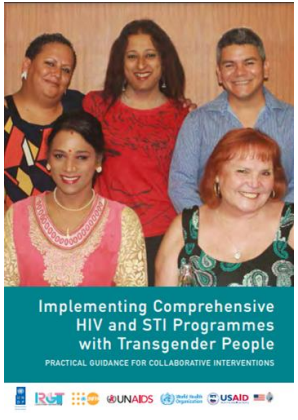
HIV Programming at Scale for and with Key Populations

Allocation Period 2023-2025

Date published: October 2019
Date updated: 20 December 2022

THE GLOBAL FUND

KEY POPULATION PROGRAMME Implementation Tools describe implementation approaches



- **SWIT**
- **MSMIT**
- **TRANSIT**
- **IDUIT**

These tools contain practical advice on implementing HIV and sexually transmitted infection (STI) programmes with key populations

This resource is available in English, French, Russian, and Spanish

https://hivpreventioncoalition.unaids.org/resources/