



Ministry of Health

# **NATIONAL GUIDELINES FOR HIV/STI PROGRAMMING WITH KEY POPULATIONS**

**National AIDS and STI  
Control Programme**

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# National Guidelines for HIV/STI Programming with Key Populations

**National AIDS and STI  
Control Programme**

OCTOBER 1, 2014



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# Foreword

Key populations (Female sex workers, Men having sex with Men and Injecting drug users) contribute around 30 % of new HIV infections in Kenya. They disproportionately have higher HIV prevalence rates ranging from 29.3% among female sex workers, 18.2 % among MSMs and 18.3 % among injecting drug users. NASCOP on behalf of Ministry of Health has spearheaded the HIV prevention, treatment and care efforts to halt and reverse the epidemic amongst the key populations. Currently, there are around 80 programs that work with key populations that are majorly funded by PEPFAR and Global Fund and we acknowledge their continued support.

The Kenya National HIV Strategic Framework (KASF) 2014 – 2019 proposes a renewed focus on key populations that include Sex Workers (both male and female), Men having Sex with Men and People who inject drugs as they are the key drivers of HIV epidemic in the country and are at higher risk of acquiring and transmitting HIV/ STI . There is need to cover them under the relevant thematic areas of comprehensive HIV prevention, treatment and care services. KASF has articulated a strategy of combined interventions that focus on reducing the risk of HIV transmission through changes in sexual

behaviours, changes in underlying structures like social norms, poverty, gender inequities, stigma and through biomedical interventions in line with the national prevention roadmap adopted in June 2014.

To address key populations, The National AIDS and STIs Control Programme (NASCOP) and partners have developed an integrated National Guidelines for HIV/STI Services for key populations. These guidelines provide a framework to all implementing partners and their donors working with key populations at national and county levels to create an enabling environment, support key populations to reduce their own risk of HIV/STI acquisition and/or transmission. The guidelines detail how to implement the behavioural, biomedical and structural interventions.

These guidelines is premised on the Kenya vision 2030 and the Ministry of Health would like to thank NASCOP, the donors, key populations community and its representatives and the technical support unit for leading and finalizing these guidelines. We expect that all partners and donors embrace these guidelines and realign their work around this new guidance.



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# Acknowledgements

These guidelines are the result of the efforts of several individuals and organisations that contributed to their development, editing, review, printing, and dissemination under the leadership of the NASCOP Key Populations Programme and Technical Support Unit.

Development of national guidelines for HIV/STI programming for key populations began through a consultative process in mid-2013, as this was seen as an important step towards improving national response using combination prevention approaches for key populations' programmes and also expanding the previous sex workers guidelines. Several key population partners and community members participated in a series of meetings, consultations and workshops to develop and finalize these guidelines.

Based on these community consultations, NASCOP set up a smaller core team on behalf of the Technical Working Group to develop and finalize the guidelines. The core team was chaired by the manager of NASCOP's Key Populations Programme. The core team members were as follows: Helgar Musyoki (NASCOP), Dr. George Githuka (NASCOP), John Anthony (NASCOP TSU), Lorna Dias (NASCOP TSU), Parinita Bhattacharjee (NASCOP TSU), Patrick Mutua (NASCOP), Jennifer

Galbraith (CDC), Japheth Nyambane (NASCOP), George Victor Owino (IAVI), Catherine Mukundi (HWWK), James Serembe (NASCOP) and Bernard Ogwang (NASCOP TSU). Thanks to Redemtor Atieno for supporting designing and printing of these guidelines. NASCOP wishes to acknowledge their key role in developing this documents and tools. NASCOP thanks Brooks Anderson for editing this document.

NASCOP gratefully acknowledges the key population members and organizations for validating and supporting the process of developing these guidelines. We extend our appreciation to CDC, USAID, KELIN, UNODC, UNAIDS, WHO, University of Manitoba, University of Nairobi, Intrahealth, Kenya Red Cross, KANCO, KENPUD, KESWA, HOYMAS, GALCK, BHESP, ICRH, IMC, IRDO, NOSET, SAPTA, LVCT, MEWA, Reachout Trust, Jinsiangu, NYARWEK, KIPE, MAYGO, HWWK, FAIR, Pathfinder and others who participated in various deliberations that helped crystallize the document.

NASCOP, on behalf of the Ministry of Health, remains committed to coordinating the key population programmes to achieve zero new infections, zero deaths, and zero stigma and discrimination, and contributing to Kenya's Vision 2030.



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# Abbreviations

|       |                                                                    |
|-------|--------------------------------------------------------------------|
| ART   | Antiretroviral Therapy                                             |
| BCC   | Behaviour Change Communication                                     |
| CASCO | County AIDS STI Coordinator                                        |
| CBO   | Community-Based Organisation                                       |
| CDC   | Centres for Disease Control and Prevention                         |
| CIN   | Cervical Intraepithelial Neoplasia                                 |
| CITC  | Client-Initiated Counselling and Testing                           |
| EBI   | Evidence-Informed Behavioural Intervention                         |
| EC    | Emergency Contraception                                            |
| FBO   | Faith-Based Organisation                                           |
| FSW   | Female Sex Worker                                                  |
| GFATM | Global Fund for AIDS, TB, and Malaria                              |
| HIV   | Human Immunodeficiency Virus                                       |
| HPV   | Human Papillomavirus                                               |
| HTC   | HIV Testing and Counselling                                        |
| ICC   | Inter-Agency Coordinating Committee                                |
| IEC   | Information, Education, and Communication                          |
| IUD   | Intrauterine Device                                                |
| KAIS  | Kenya AIDS Indicator Survey                                        |
| KASF  | Kenya AIDS Strategic Framework                                     |
| KNASP | Kenya National AIDS Strategic Plan                                 |
| KP    | Key Population                                                     |
| MARP  | Most-at-Risk Population (now referred to as Key Populations)       |
| MAT   | Medically Assisted Therapy                                         |
| MSM   | Men Who Have Sex with Men                                          |
| MSW   | Male Sex Worker                                                    |
| NAAT  | Nucleic Acid Amplification Test                                    |
| NACC  | National AIDS Control Council                                      |
| NASCO | National AIDS & STI Control Programme                              |
| NGO   | Non-Governmental Organisation                                      |
| NSP   | Needle and Syringe Programme                                       |
| PEP   | Post-Exposure Prophylaxis                                          |
| PHDP  | Positive Health, Dignity, and Prevention                           |
| PITC  | Provider-Initiated Testing and Counselling                         |
| PPT   | Periodic Presumptive Treatment                                     |
| PRC   | Post-Rape Care                                                     |
| PrEP  | Pre-Exposure Prophylaxis                                           |
| PWID  | People Who Inject Drugs                                            |
| SM    | Social Marketing                                                   |
| SRH   | Sexual and Reproductive Health                                     |
| STI   | Sexually Transmitted Infection                                     |
| TB    | Tuberculosis                                                       |
| TG    | Transgender (in this case transgender women who have sex with men) |
| TWG   | Technical Working Group                                            |
| USAID | United States Agency for International Development                 |
| VMMC  | Voluntary Medical Male Circumcision                                |
| WHO   | World Health Organization                                          |

# Glossary<sup>1</sup>

**Key populations** are defined groups who, due to specific higher-risk behaviours, are at increased risk of human immunodeficiency virus (HIV) irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These guidelines focus on three key populations: 1) female, male, and transgender sex workers, 2) men who have sex with men, and 3) people who inject drugs. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.<sup>2</sup>

**Sex workers** include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less 'formal', or organized.<sup>3</sup> As defined in the Convention on the Rights of the Child, children and adolescents under the age of 18 who exchange sex for money, goods, or favours are 'sexually exploited' and not defined as sex workers.<sup>4</sup>

**Men who have sex with men** refers to all men who engage in sexual and/or romantic relations with other men. The words 'men' and 'sex' are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group. Men who

have sex with men in Kenya also reflect a range of sexual and gender identities<sup>5</sup> while many also have sex with women.<sup>6</sup> It should be noted that not all males who have sex with men identify themselves as homosexuals or even as men.<sup>7</sup>

**People who inject drugs** refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes. People who self-inject medicines for medical purposes—referred to as 'therapeutic injection'—are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. While these guidelines focus on people who inject drugs because of their specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment, much of this guidance is relevant also for people who inject other substances.

**Transgender** is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender, or otherwise gender non-conforming.<sup>8,9</sup> Transgender people may self-

1 Definitions adapted from WHO. 2014. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

2 WHO. 2011. *Global Health Sector Strategy on HIV/AIDS 2011–2015*. Geneva: WHO. [http://whqlibdoc.who.int/publications/2011/9789241501651\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf)

3 WHO. 2012. *Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low and Middle-Income Countries: Recommendations for a Public Health Approach*. Geneva: WHO. [http://www.who.int/iris/bitstream/10665/77745/1/9789241504744\\_eng.pdf](http://www.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf)

4 United Nations. Convention on the Rights of the Child. Geneva: United Nations General Assembly, 20 November 1989. <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

5 NACC and Population Council. 2009. *The Overlooked Epidemic: Addressing HIV Prevention and Treatment among Men Who Have Sex with Men in sub-Saharan Africa*. Report of a consultation, Nairobi, Kenya, 14–15 May 2008. Nairobi: Population Council. [http://www.popcouncil.org/uploads/pdfs/HIV\\_KenyaMSMMeetingReport.pdf](http://www.popcouncil.org/uploads/pdfs/HIV_KenyaMSMMeetingReport.pdf)

6 Onyango-Ouma W, Birungi H, and Geibel S. 2005. *Understanding the HIV/STI Risks and Prevention Needs of Men Who Have Sex with Men in Nairobi, Kenya*. Horizons Final Report. Washington, D.C.: Population Council. <http://www.popcouncil.org/uploads/pdfs/horizons/msmkenya.pdf>

7 NACO (National AIDS Control Organization). 2007. *Targeted Interventions under NACP III: Operational Guidelines Vol. 1. Core High Risk Groups*. New Delhi: Ministry of Health and Family Welfare, Government of India. <http://www.naco.gov.in/upload/Publication/NGOs%20and%20targetted%20Interventions/NACP-III.pdf>

8 Carroll A. 2014. *Testing the waters: LGBT people in the Europe & Eurasia region*. Washington, D.C.: United States Agency for International Development. <http://www.usaid.gov/sites/default/files/documents/2496/USAID%20Testing%20Waters%20Report%20on%20LGBT%20Europe%20and%20Eurasia.pdf>

9 World Professional Association for Transgender Health. 2012. *Standards of care for the health of transsexual, transgender, and gender-nonconforming people*. Minneapolis, MN, USA: World Professional Association for Transgender Health. [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351)

identify as transgender, female, male, transwoman or transman, trans-sexual, or, in specific cultures, as hijra (India), kathoey (Thailand), waria (Indonesia), or one of many other transgender identities. They may express their genders in a variety of masculine, feminine, and/or androgynous ways. The high vulnerability and specific health needs of transgender people necessitates a distinct and independent status in the global HIV response.

Sexual risk differs among different subgroups within the transgender community. For example, sexual risk may be higher among transgender women (male to female) or transgender men (female to male) who have receptive anal intercourse with men than among transgender men or transgender women who have sex only with women. The prevalence of HIV among transgender women in many countries is as high as or higher than among men who have sex with men. Owing to these differing sexual risk profiles, the focus of this consolidated guideline is on transgender women or transgender men who have sex with men rather than on transgender women and transgender men who have sex only with women.<sup>10</sup>

### Statement on Sex Work, Trafficking, and Sexual Exploitation of Minors

By definition, sex workers are 'female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally.'<sup>11</sup> Sex worker organisations globally, and locally, understand sex work as a contractual arrangement where sexual services are negotiated between consenting adults, with the terms of engagement having been agreed upon between the seller and the buyer of sexual services. It is important to note that sex work takes many forms, varies in the degree to which it is 'formal' or organised, and varies between and within countries and communities. According to international treaties, trafficking in persons is defined as 'the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or

of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.'<sup>12</sup>

Not all women and men engaged in sex work are trafficked. Many engage in sex work voluntarily for economic or social reasons. These guidelines address sex work and not sex trafficking. It is important that individuals involved in combating human trafficking understand that not all sex workers are coerced or forced into sex work and therefore are not trafficked into sex work. We believe victims of trafficking should be liberated and assisted.

With regards to the sexual exploitation of minors and underage persons seeking HIV-related services, according to the *High Income Countries Issue Brief*, the Convention on the Rights of the Child (CRC) sets out for children (under 18 years of age),

▶ among other rights, the right to non-discrimination; the right to life, survival, and development; the right to have views affecting the child heard and given due weight, in accordance to age and maturity of the child; the right to privacy; the right to access information and material aimed at promotion of their social, spiritual, and moral well-being and physical and mental health; and the right to the highest attainable standard of health, which imposes upon the State an obligation to take appropriate measures to develop preventive health care, guidance for parents, and family planning education and services.<sup>13</sup>

In General Comment 14 on the right to the highest attainable standard of physical and mental health, the United Nations Committee on Economic, Social and Cultural Rights states,

▶ The Convention on the Rights of the Child directs States to ensure access to essential health services [and] . . . links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. . . . States' parties should provide

10 WHO. 2011. *HIV Prevention in Generalized Epidemics: Optimal Interventions for Global Fund Applications: Recommendations for a Public Health Approach*. Geneva: World Health Organization. [http://whqlibdoc.who.int/publications/2011/9789241502467\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502467_eng.pdf).

11 UNAIDS. 2012. *Guidance Note on HIV and Sex Work*. Geneva: UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306\\_UNAIDS-guidance-note-HIV-sex-work\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf).

12 United Nations. 2000. *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (Palermo Protocol)*. [http://www.uncjin.org/Documents/Conventions/dcatoc/final\\_documents\\_2/convention\\_%20traff\\_eng.pdf](http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf)

13 UNDP. 2011. *High Income Countries Issue Brief: Rights of Children and Young People to Access HIV-Related Services*. New York: UNDP.

a safe and supportive environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realisation of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.<sup>14</sup>

In General Comment 4, regarding adolescent health and development, the Committee on the Rights of the Child recognises that adolescence is a period characterised by rapid changes, including sexual and reproductive maturation, which can pose new challenges to their health and development owing to their relative vulnerability and pressures from society to adopt risky health behaviours, including the challenge of developing an individual identity and dealing with one's sexuality. In this regard, the Committee calls on States to

- ▶ ... ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible. To this end, States parties are urged (a) to develop effective prevention programmes, including measures aimed at changing cultural views about adolescents' need for contraception and STD prevention and addressing cultural and other taboos surrounding adolescent sexuality; (b) to adopt legislation to combat practices that either increase adolescents' risk of infection or contribute to the marginalisation of adolescents who are already infected with STDs, including HIV; (c) to take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.<sup>15</sup>

Guideline 8 of the *International Guidelines on HIV/AIDS and Human Rights* provides,

- ▶ States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing

underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.<sup>16</sup>

The *Issue Brief* adds,

- ▶ Girls are particularly vulnerable to violence, coercion and lack of control over their sexual and reproductive health. Therefore, policies and legislation must be attuned to the specific issues, differing vulnerabilities and needs of young women, and be equally approached for all youth - including young men, lesbian, gay, bisexual and transgendered youth, as well as marginalised groups such as street youth.<sup>17</sup>

In General Comment 4, the Committee on the Rights of the Child calls on States to

- ▶ ... ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity.<sup>18</sup>

... provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs) ... regardless of their marital status and whether their parents or guardians consent.<sup>19</sup>

Misconceptions regarding the legal standards regarding minors' consent to medical services may act as a barrier to the realisation of their reproductive and sexual health rights.<sup>20</sup> Health service providers may assume that minors (or those below the official age of consent in a given jurisdiction) require parental consent to obtain services or that parent must be informed when a minor accesses services. Sometimes, parental

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> Cook RJ, Erdman JN, and Dickens BM. Respecting adolescents' confidentiality and reproductive and sexual choices. *International Journal of Gynecology and Obstetrics*. 2007;98(2):182-7. doi: <http://dx.doi.org/10.1016/j.ijgo.2007.04.018>. See also Sannisto T and Kosunen E. Promotion of adolescent sexual health in primary care: survey in Finnish health centres. *The European Journal of Contraception and Reproductive Health Care*. 2009;14(1):27-38. doi: 10.1080/13625180802460509

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

involvement is not realistic or desirable, as there may be competing interests between the adolescent and the parent.<sup>21</sup> A majority of children report that confidentiality is the most important quality of a sexual health service.<sup>22</sup> In order to avoid parental disclosure, children may forgo reproductive health care or may not be honest with healthcare providers when seeking services, thereby putting their sexual health in jeopardy.<sup>23</sup>

It's also important to note that Section 14 (1) b of the HIV Prevention and Control Act<sup>24</sup> provides that no person shall undertake an HIV test on a child, without the written consent of a parent or legal guardian of the child: Provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test.

While programming for minors exploited by the sex industry is beyond the scope of this guideline, below are seven key principles that should guide HIV programming with most-at-risk adolescents.<sup>25</sup>

### The best interest of the child is paramount

1. Adolescents requiring protection from commercial sexual exploitation should be referred to appropriate agencies, and it is the duty of States to provide assistance aimed at their physical and psychological recovery and social integration.
2. Policy makers and health care providers need to consider whether the adolescent has the 'competence' to provide consent to services, and whether others should be involved in decision making on their behalf.

- Adolescents who are able to understand the risks and benefits of HIV prevention and treatment services should be able to access them without parental consent.
- Adolescents who lack the capacity to understand the risks and benefits of HIV prevention and treatment services should be able to access them only with parental consent.

3. Competence is an element of informed consent and can be assessed only through counselling by trained service providers.
4. The duty of confidentiality owed to a person under 18 is as great as that owed to an adult.
5. Confidentiality should be broken only if an adolescent requires immediate protection.
6. Any HIV services provided for minors should not discriminate between the local population and national minorities—both should have equal access to such services.<sup>26</sup>

21 Robertson DG. Adolescent consent in reproductive and sexual health decision-making: should there be an arbitrary age of consent or should it be based on the 'evolving capacities of the child'? *Journal of Pediatric Adolescent Gynecology*. 2008;21(1):47-51. doi: 10.1016/j.jpjag.2007.08.002.

22 Thomas N, Murray E, and Rogstad KE. Confidentiality is essential if young people are to access sexual health services. *International Journal of STD & AIDS*. 2006;17(8):525-529. doi: 10.1258/095646206778145686. See also Nwokolo N. et al. Young people's views on provision of sexual health services. *Sexually Transmitted Infections*. 2002;78(5):342-345. doi:10.1136/sti.78.5.342

23 Cook RJ, Erdman JN, and Dickens BM. Respecting adolescents' confidentiality and reproductive and sexual choices. *International Journal of Gynecology and Obstetrics*. 2007;98(2):182-7. doi: http://dx.doi.org/10.1016/j.ijgo.2007.04.018. See also Jones RK et al. Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception. *JAMA*. 2005;293(3):340-348. doi:10.1001/jama.293.3.340. See also Thomas N, Murray E, and Rogstad KE. Confidentiality is essential if young people are to access sexual health services. *International Journal of STD & AIDS*. 2006;17(8):525-529. doi: 10.1258/095646206778145686.

24 Chapter 246 A of the Laws of Kenya

25 Homans H. 2008. *Ethical and Protection Issues in HIV Programming for Adolescents Engaging in HIV Risk Behavior* (draft). UNICEF CEE/CIS. [http://www.unicef.org/ceecis/Ethical-Protection\\_Guidance\\_for\\_MARA\\_Programming\\_-\\_Working\\_Doc.pdf](http://www.unicef.org/ceecis/Ethical-Protection_Guidance_for_MARA_Programming_-_Working_Doc.pdf)

26 Ibid.

# Introduction

The Government of Kenya, through the National AIDS Control Council (NACC), initiated HIV-prevention programming for populations at elevated risk for HIV within the second Kenya National AIDS Strategic Plan period (2005-2010). This was premised on increased global recognition that HIV-related morbidity and mortality were significantly higher among key populations—namely, sex workers (male, female, and transgender), clients of sex workers, men who have sex with men (MSM), transgender women (TG), people who inject drugs (PWID), and members of the adult population whose livelihoods were inextricably linked with the sex trade, such as the fishing community. It was also recognized that clients of sex workers and men who have sex with men can function as epidemiological bridges by which HIV spreads from key populations to the general population.<sup>27</sup>

However, the outcomes for key population programmes were not clearly defined nor incorporated within the national monitoring and evaluation framework. Consequently, between 2005 and 2008, difficulties in tracking the results of uncoordinated research and inadequate prevention, care, and treatment programmes for key populations demonstrated the need for national monitoring and coordination and enhanced implementation structure.

Using this evidence in conjunction with findings from the *Kenya AIDS Indicator Survey* (2007) and recommendations from the decentralized *Joint HIV and AIDS Programme Review* (2008), the Government of Kenya revised the existing national HIV programming framework and prioritized comprehensive targeted programming for key populations in the *Kenya National AIDS Strategic Plan 2009/10–2012/13* (KNASP III).

In 2009, evidence from the Kenya Modes of Transmission Study confirmed the concentrated epidemic among female sex workers (FSW), men who

have sex with men, and people who inject drugs; their 33% contribution to new HIV infections in Kenya; and the fact that these key populations were grossly underserved by the national HIV response.

To support the delivery of KNASP III, the National AIDS and STI Control Programme's Key Population Technical Working Group (NASCOP KP TWG) was established through the Closing the Tap initiative in 2009. Led by the NASCOP Key Populations Programme Manager, the TWG is comprised of representatives from implementing organisations working with and for female, male, and transgender sex workers (SW), MSM, and PWID; key-population -led organisations; academic and research institutions, and development partners. The TWG's role is to ensure the efficient and effective design, implementation, monitoring, and coordination of key population programming at national and local levels.

In order to operationalise the national strategic framework, the TWG has been responsible for developing various national operational guidelines, including the existing *National Guidelines for HIV/STI Programs for Sex Workers* (2010) upon which these revised guidelines are based. Implementation of key population programming aligned to the KNASP III, the End Term Review findings, and international best practices and guidelines have informed changes to the existing guidelines.

Other national guidelines produced include the *Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use*; standard operating procedure manuals for needle and syringe exchange programmes and medically assisted therapy (2013), the national peer educators manual for sex workers (draft), and *Standards for Peer-Education and Outreach Programs for Sex Workers* (2010).

The end of the KNASP III term in 2013—combined with extensive changes in Kenyan leadership, in governance structures, and in the overarching public health response—provides context for the

<sup>27</sup> Kenya National AIDS Strategic Plan II (2005/6–2009/10). [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_127530.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127530.pdf)

development of the 4th National HIV Strategic Framework and an enabling structural environment for key population programming. Going forward, the main goals of targeted prevention are to reduce new HIV/STI infections among key populations and to slow HIV/STI transmission between key populations and bridge populations and between key populations and the general population.

In the last five years, programmes have been scaled up among the key populations. There have, however, been challenges related to implementation of these interventions. The interventions focus on different elements of the programme, as there have been no agreed-upon national standards. Due to perceived criminality, the key populations in Kenya have been vulnerable to harassment, extortion, and institutionalized stigma and discrimination, which hinder their ability to access HIV and health care services. This also impedes the scaling up of HIV care and treatment programmes among these populations.

To establish a supportive framework that enhances the quality, accessibility, and performance of all services for key populations, NACC and NASCOP, through the National KP Steering Committee housed at NACC, have spearheaded the development of a new Key Populations Policy.

The policy is in line with Article 43(1)(a) of the Constitution of Kenya (which states that every citizen has the right to the highest attainable standard of health); with international human rights instruments to which Kenya is a party, and which therefore form a part of the country's legal system by virtue of Article 2(6) (which states that any treaty or convention ratified by Kenya shall form part of the law of Kenya); and with the provision of the HIV and AIDS Prevention and Control Act no. 14 (2006) (which prohibits discrimination against people living with HIV). The policy is also in response to a need identified by the KNASP III End Term Review, which observed that the absence of specific policy and legal enforcement tools to address the needs of key populations was impeding the scale-up of HIV prevention among such populations.

The policy envisions creating a facilitating environment wherein all key populations in Kenya can access HIV prevention, care, support, and treatment programmes through a rights-

based approach. Modelling conducted in Kenya estimates that 20,683 new infections among the adult population may be averted between the years 2012 and 2016 through community-empowerment-based comprehensive HIV-prevention coverage of 65% of sex workers.<sup>28</sup> Such prevention will considerably reduce the burden on the HIV care programme in Kenya.

### Rationale for Consolidated Guidelines on Key Populations

NASCOP has developed guidance on programming for sex workers and PWID, but those guidelines do not adequately address issues common to all key populations or provide thorough operational direction for programme implementation. Hence, there was a need for a document that provides guidelines for all key population programmes and explains their implementation.

### Goals of the Guidelines

These guidelines were formulated to reduce HIV transmission in Kenya by informing and standardizing the development and implementation of HIV programmes and services for key populations.

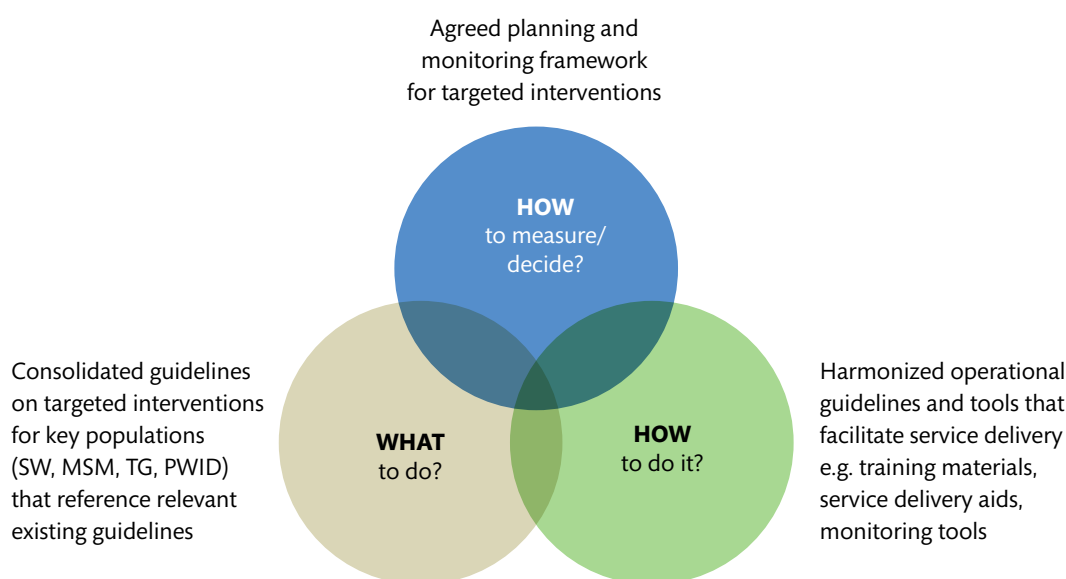
### Purpose of the Guidelines

**The purpose of these guidelines is to ensure the delivery of quality HIV-prevention interventions to populations at increased risk of HIV infection through the Kenya AIDS Strategic Framework (KASF).**

To achieve their purpose, the guidelines

- consolidate and define the combination prevention package for key populations,
- inform partners how to operationalise intervention components,
- share the programme coordination and management framework at national and sub-national levels, and
- define the programme monitoring and evaluation parameters for targeted interventions with key populations.

<sup>28</sup> Kerrigan D et al. 2013. *The Global HIV Epidemics among Sex Workers*. Washington, D.C.: World Bank. <http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongSexWorkers.pdf>

Figure 1: **Guidelines' Programming Framework**

### Scope of the Guidelines

The previous *National Guidelines for HIV/STI Programs for Sex Workers* (2010) focused primarily on combination prevention programming for female sex workers. The scope of these guidelines has been broadened to encompass not only male, transgender, and female sex workers but also men who have sex with men, and people who inject drugs.

Building on the previous national guidelines, these guidelines have included and further outlined critical operational considerations, such as estimating the size of key populations, macro- and micro-planning, and cross-cutting programme areas. These guidelines also contain special-consideration sections covering components unique to each subpopulation, the delineation of an essential intervention package vis-à-vis an expanded intervention package, programme management and capacity strengthening, and an enhanced structural intervention component highlighting community engagement and violence mitigation.

During the development of these guidelines, the following critical gaps were identified within the existing guidelines and overall HIV/STI programming for key populations: 1) a lack of methodologies to translate theoretical concepts and components into practice and 2) the lack of a coordinated and standardized

programming approach for key populations. Although many implementing partners already have distinct methodologies, these guidelines suggest methodologies that will harmonize the ongoing interventions, coordinate scale-up of key population programming, and enable more effective and efficient programme implementation.

As shown in Figure 1, these guidelines address three key aspects of programming:

**What to do**—the provision of consolidated guidelines for targeted interventions for key populations.

**How to do it**—the provision of clear instruction for implementing the guidelines.

**How to decide**—the articulation of milestones and indicators against which to assess results.

These guidelines have been presented in three interrelated chapters.

**Chapter 1** describes the HIV/STI context of key population programming in Kenya, from epidemiology to subpopulation characteristics.

**Chapter 2** describes comprehensive combination prevention interventions for key populations and how to operationalise them.

**Chapter 3** outlines the programme coordination and management framework from grassroots to the national level, including monitoring and evaluation, and the parameters for programme reporting to the national grid.

### Users of the Guidelines

This document is designed for use by policy- and implementation-level HIV and STI programme managers, implementing partners (community-based organisations, faith-based organisations, and nongovernmental organisations), and health service providers. It may also be used by other agencies that work with and for key populations, including development/funding agencies and partners, government policy makers, and advocates.

### Process of Developing the Guidelines

This guideline was developed through a collaborative process led by NASCOP under the auspices of the Ministry of Health. Stakeholder meetings bringing together decision makers, development and implementing partners, male and female sex workers, men who have sex with men, transgender women, and people who inject drugs were convened nationally and regionally to discuss, validate, and finalize the HIV/STI package and guidelines. Guidelines from countries in Africa, Europe, and Asia, and the guidelines of the WHO and UNAIDS, were consulted while developing these guidelines.

## GUIDING PRINCIPLES FOR HIV PREVENTION AMONG KEY POPULATIONS

Certain principles should be kept in mind when designing and implementing HIV interventions. HIV-prevention programmes should be designed according to the local HIV epidemic and the needs of local key populations. This will ensure that funding is spent most effectively and programmes have the greatest impact on reducing new infections among key populations.

### Guiding Principles for Key Population Programme Design

- Ensure interventions do no harm.
- Uphold the human rights of key populations and accord them basic dignity (e.g., service use should be voluntary, not mandatory).
- Respect the views, knowledge, and life experiences of key populations.
- Recognize that key populations are part of the solution, as they are usually highly motivated to improve their health and well-being.
- Prepare key populations for leadership and ownership of HIV prevention programmes.
- Create an enabling environment through advocacy with stakeholders and authorities.
- Adapt to the diversity of key population settings and people involved.

| Timeline | Process/Activity                                                                                                                     |
|----------|--------------------------------------------------------------------------------------------------------------------------------------|
| May 2013 | Process initiated                                                                                                                    |
| End May  | TWG convened to identify gaps in existing SW Guidelines & make recommendations for FSW/MSM/MSW Guidelines relevant to Kenyan context |
| Jun/Jul  | 1st draft developed & internally reviewed (NASCOP & TSU)                                                                             |
| Aug/Sep  | 2nd draft finalized & Internal review (TSU)                                                                                          |
| Oct/Nov  | 3rd draft finalized & circulated to community, TWG & NASCOP for review                                                               |
| Feb 2014 | Community consultations & feedback                                                                                                   |
| Feb 2014 | TWG review meeting                                                                                                                   |
| Mar-Jun  | Consultations with technical teams/experts & editing                                                                                 |
| Jul 2014 | Validation meeting & presentation for approval                                                                                       |
| Nov 2014 | Finalization & printing                                                                                                              |

To ensure increased uptake of the HIV/STI package of services, components need to be community owned. Additionally, community-centric services need to aspire to the following:

### **Know Your Epidemic, Know Your Response**

Programme implementers should conduct needs assessments among key populations. Knowing the number and locations of people with behaviours that put them at increased risk enables epidemiologists to estimate the future course of the HIV epidemic. Information about the local HIV epidemic and the local key populations should be used to plan where to intervene, what services to offer, how to deliver them, and what the programme targets should be.

### **Adapt Proven Methods to Local Needs**

All decisions and actions at the level of policy making, planning, or implementation should be based on the latest information and best practices adapted to local settings. HIV-prevention interventions should prioritize intervention techniques that have been proven effective in scientific literature and adapt these techniques to address local needs.

### **Accessible Services**

Health services should be conveniently located (e.g., near the identified hot spots and shooting galleries) and open at hours that are acceptable to key populations. Whenever possible, services should be integrated, co-located, and/or mobile to expand coverage and to broaden the range of health services accessible in a single visit (e.g., STI services with HIV testing and counselling, and care and support services for people living with HIV).

### **Acceptable Services**

HIV/STI/reproductive health interventions should be not only accessible but also acceptable to key populations. Interventions must be based on the needs of local key populations. Therefore, key population members should be involved in all stages of programme planning, implementation, monitoring, and evaluation to ensure interventions are timely and responsive to current needs. Service providers should be sensitive, non-judgemental, non-stigmatizing, and trained on the specific health needs and concerns of key populations (e.g., rectal examinations for anal STI management, substance use assessments). Health services must be confidential and voluntary to ensure that the safety

and human rights of key populations are protected. Service providers need to ensure an adequate and uninterrupted supply of male and female condoms, water-based lubricants, non-rationed and safe injection materials—the latter for PWID. Any health services provided to key populations must be in line with international standards, current best-practices, and national guidelines.

### **Affordable Services**

The costs of services and of transportation to and from services can be barriers for low-income individuals. Therefore, services targeting key populations must be free or affordable. Programmes are advised to offer subsidized or free services and commodities (i.e., male and female condoms and water-based lubricants) to ensure that all members of key populations have access to the essential HIV/STI package of services described in Chapter 2.

### **Community-Centred or Led**

Programmes should consult with key populations; train members to participate in planning, running, and monitoring the programme; and ensure that members are involved. Members of the community should be involved in programme advisory committees. Programmes should incorporate community knowledge and develop the capacity of the community to take ownership of the programme for long-term sustainability.

### **Non-Discriminating**

Promotion, protection, and respect of human rights, including gender equality, should always be integrated in HIV-prevention programming for key populations. All citizens have the right to information and health services.

### **Maintaining Confidentiality and Protection of Data**

Client data, especially that which identifies individuals and locations, should be treated with care so that it does not fall into the wrong hands. For example, the police—who have a mandate to curtail illegal activities—might use such data to identify and prosecute sex workers. Sensitive data should be stored under lock and key. Aggregate estimates of key population size should not be given to the media, as the publication of such figures may result in unintended political or law enforcement action. Such publicity or prosecution could push high-risk groups underground, further increasing their vulnerability to HIV.

# HIV Epidemiology and Key Populations in Kenya

## CONTENTS

*Chapter 1 presents the contextual ‘who’ and ‘why’ driving the Kenya’s HIV epidemic.*

- 1.1 Introduction
- 1.2 HIV in Kenya—A Mixed Epidemic
  - 1.2.1 HIV in Key Populations
  - 1.2.2 Estimates of Key Populations
- 1.3 Risk and Vulnerability
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# 1.1

## INTRODUCTION

The recent move toward more strategic use of HIV resources draws attention to the value of addressing HIV in key populations. In both concentrated and generalized epidemics, greater investment in a country's key populations is likely to improve the cost-effectiveness of the response to HIV. In Kenya's mixed epidemic, key populations account for 33% of all new infections.

Investment in key populations is cost-effective because of the central role of key populations in the dynamics of epidemics. People from key populations can transmit HIV to other populations—for example, sex workers' clients and the sexual partners of people who inject drugs. Thus, infections in people from key populations can have a multiplier effect. A modelling exercise undertaken in Kenya showed that when a community-empowerment-based comprehensive HIV-prevention intervention<sup>29</sup> is brought to scale from a baseline coverage level of 5% to 100% in five years, it can show a range of impacts on HIV: 10,800 infections in Kenya were averted in five years among female sex workers. Impacts of the intervention for female sex workers extend to the adult population, cumulatively averting 20,700 adult infections in Kenya.<sup>30</sup>

# 1.2

## HIV IN KENYA—A MIXED EPIDEMIC

Since Kenya recorded its first case of HIV in 1984, the AIDS epidemic has evolved to become one of the central impediments to national health, well-being, and development. In the 1990s, HIV spread rapidly in Kenya, reaching prevalence rates of 30% in some antenatal care sites—with major social

and economic consequences throughout society.<sup>31</sup> In 1999, the Government of Kenya declared HIV a national disaster and established the National AIDS Control Council to coordinate a multisectoral national response.

Kenya has the third-largest population of people living with HIV in sub-Saharan Africa and the highest national HIV prevalence of any country outside of Southern Africa. Within its counties, there are important variations in HIV burden.<sup>32</sup> Findings of the Kenya AIDS Indicator Survey (2012) indicated that approximately 5.6% of the adult population aged 15–64 years is HIV-infected.<sup>33</sup> However, rates of HIV prevalence vary by demographic groups and geographic areas. HIV prevalence is higher among women (6.9%) than men (4.4%). The highest HIV prevalence rates in the country are in Nyanza region (15.1%), followed by Nairobi (4.9%), Western (4.7%), and Coastal (4.3%) regions. Adults in Kenya's urban areas have been found to have higher HIV prevalence (6.5%) than adults in rural areas (5.1%).

Kenya's HIV epidemic is classified as a mixed epidemic, meaning that it is generalized among the general population and concentrated among key populations that are especially at risk of infection.<sup>34</sup> The generalized epidemic is driven by sero-discordance, unprotected sex, multiple and concurrent partnerships, low rates of male circumcision among some cultural groups, and unawareness of HIV status. The concentrated epidemic is driven by high-risk sexual behaviour, such as unprotected anal or vaginal sex, drug-related HIV-risk behaviour, such as unsafe injection practices, and structural factors that heighten the vulnerability of key populations.

### 1.2.1 HIV in Key Populations

According to the Kenya HIV Prevention Responses and Modes of Transmission Analysis (2008), conducted by NACC, approximately 33% of all new infections in the country are attributed to key populations, as shown in Figure 2. A meta-analysis conducted by Baral et al. found that the

29 This approach to HIV prevention includes sex worker organization, mobilization, and collective action to address social and structural factors related to sex worker rights, health and HIV risk. It also considers more traditional programmatic elements, including community-led peer education, condom distribution, and STI/ HIV screening and treatment.

30 Wirtz AL et al. Epidemic impacts of a community empowerment intervention for HIV prevention among female sex workers in generalised and concentrated epidemics. *PLoS ONE*. 2014; 9(2): e88047. doi:10.1371/journal.pone.0088047. <http://www.plosone.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0088047&representation=PDF>

31 *The Kenya National AIDS Strategic Plan II (KNASP)*, 2005/06–2009/10. [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_127530.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127530.pdf)

32 NACC and NASCOP. 2014. Kenya HIV Estimates

33 NASCOP. 2014. *Kenya AIDS Indicator Survey 2012*. Final Report. Nairobi: NASCOP [http://www.nacc.or.ke/attachments/article/403/KAIS\\_II\\_2014\\_Final\\_Report.pdf](http://www.nacc.or.ke/attachments/article/403/KAIS_II_2014_Final_Report.pdf)

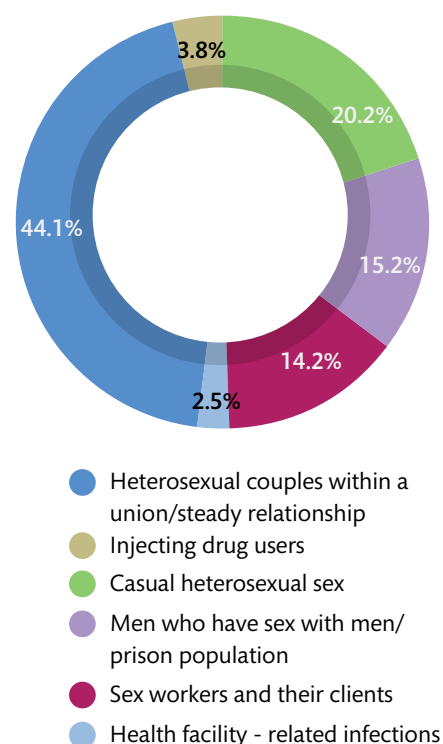
34 See Annex 1 for more information about HIV epidemiology.

HIV prevalence among FSWs in Kenya was around six times greater than among adult women in the general population (45% vs. 7%).<sup>35</sup> In a meta-analysis of HIV prevalence among MSM and adults of reproductive age, Baral and his team found that HIV prevalence among MSM in Kenya is higher (11%) compared to adults of reproductive age (7%).<sup>36</sup> In 2007 in Mombasa, HIV prevalence among MSM/MSWs with exclusively male partners was 41%.<sup>37</sup> The Kenya AIDS Indicator Survey in 2007 revealed that HIV prevalence in Nairobi was 18.2% among MSM, 29.3% among FSWs, and 18.7% among PWID.<sup>38</sup> When further disaggregated by sex, it was established that 49% of female injecting drug users were HIV-positive, whereas only 16% of male injecting drug users were HIV-positive. A recent rapid situational analysis of PWID in Nairobi and Coast provinces highlighted the high HIV prevalence among PWID, ranging from 17% to 47% among male and female PWID, respectively.

More recently, in a Nairobi-based prospective cohort study with MSM conducted during 2009–12, the baseline HIV prevalence was 40%. HIV incidence was found to be 10.9 per 100 person-years.<sup>39</sup> Another recent study found that overall HIV-1 incidence among 449 MSM in coastal Kenya was 8.6 per 100 person-years. Incidence was 5.8 per 100 person-years among men who reported sex with men and women, but 35.2 *per 100 person-years* among men who have sex with men exclusively.<sup>40</sup>

In the context of mixed epidemics, there is an urgent need for HIV-prevention interventions to first target key populations at greatest risk for HIV, then bridge populations who frequent high-risk venues and are involved with high-risk networks, and, finally, the general population.

Figure 2: **Prevalence Rate for New Infections (NACC, 2008)**



Programmatic focus on key populations in Kenya is based on the rationale that these populations are most vulnerable, experience the greatest burden of HIV, and are currently underserved in the country. In the KNASP III, Kenya acknowledged that without addressing the needs of key populations, a sustainable HIV response will not be achieved.

## 1.2.2 Estimates of Key Populations

Kenya has large populations of sex workers, MSM, and PWID. These populations have many connections to the general population, including sexual and drug injecting relationships, which act to bridge HIV transmission between key populations and members of the general population.

Recent mapping estimated that there are 133,675 female sex workers throughout the country, with significant regional variations, ranging from 29,494 FSWs in Nairobi Province to 2,030 in North Eastern Province. It is estimated that there are 19,175 men

35 Baral S et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *Lancet Infectious Diseases*. 2012;12(7):538–549. doi:10.1016/S1473-3099(12)70066-X

36 Baral S et al. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: A systematic review. *PLoS Med*. 2007;4(12):e339. doi:10.1371/journal.pmed.0040339 <http://www.plosmedicine.org/article/doi/10.1371/journal.pmed.0040339>

37 Sanders EJ et al. High HIV-1 incidence, correlates of HIV-1 acquisition, and high viral loads following seroconversion among MSM. *AIDS*. 2013;28(3):437–46. doi: 10.1097/QAD.0b013e32835b0f81. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3929859/pdf/nihms544598.pdf>

38 NACC. 2009. *Kenya AIDS Indicator Survey 2007*. Nairobi: NACC. [http://www.nacc.or.ke/nacc%20downloads/official\\_kais\\_report\\_2009.pdf](http://www.nacc.or.ke/nacc%20downloads/official_kais_report_2009.pdf)

39 McKinnon LR et al. High HIV risk in a cohort of male sex workers from Nairobi, Kenya. *Sex Transm Infect* 2013;90(3):237–42. doi: 10.1136/sextrans-2013-051310

40 Sanders EJ et al. High HIV-1 incidence, correlates of HIV-1 acquisition, and high viral loads following seroconversion among MSM. *AIDS*. 2013;28(3):437–46. doi: 10.1097/QAD.0b013e32835b0f81. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3929859/pdf/nihms544598.pdf>

who have sex with men and/or male sex workers, and 18,327 people who inject drugs in Kenya.<sup>41</sup> In some cities, the percentage of FSWs is as high as 15% of the adult female population. Counties with a high HIV prevalence tend to have more sex workers.

## 1.3

### RISK AND VULNERABILITY

UNAIDS defines 'risk' as 'the probability that a person may acquire HIV infection', usually as a result of specific behaviours that enable HIV transmission to occur.<sup>42</sup> An individual is 'vulnerable' to HIV when his or her ability to avoid infection is diminished by inadequate personal knowledge or skills, by cultural norms that validate risky behaviours, or by circumstances that make risk reduction difficult or impossible.<sup>43, 44, 45</sup> For key populations, many of the factors that cause vulnerability are beyond their control.

HIV prevention among key populations requires reducing their risk *and* their vulnerability. While access to condoms and access to quality treatment for STIs reduce people's HIV risk, interventions need to also address cultural, legal, economic, and other contextual factors that affect vulnerability. By influencing access to income, information, prevention services and commodities, and care and treatment, structural factors affect how well individuals or populations can protect themselves from and cope with HIV infection. Structural factors include punitive legislation and policing practices, stigma and discrimination, education, poverty, and violence.

#### Violence and Vulnerability

Violence is so common that many key populations consider violence 'normal' or 'part of the job', and do not know that violence violates their rights. As a result, they are often reluctant to report incidents

of rape, attempted or actual murders, beatings, molestation, or sexual assault to the authorities. When they do report, their claims are often disregarded.<sup>46</sup> Key populations face various forms of violence:

- **Physical violence:** Being subjected to physical force which can potentially cause death, injury, or harm. It includes, but is not limited to, having an object thrown at one, being slapped, pushed, shoved, hit with the fist or with something else that could hurt, being kicked, dragged, beaten up, choked, deliberately burnt, threatened with a weapon or having a weapon used against one (e.g., gun or knife).
- **Sexual violence:** Rape, gang rape (i.e., by more than one person), sexual harassment, being physically forced or psychologically intimidated to engage in sex or subjected to sex acts against one's will (e.g., undesired touching, oral, anal, or vaginal penetration with penis or with an object) or that one finds degrading or humiliating.
- **Emotional or psychological violence:** Includes, but is not limited to, being insulted (e.g., called derogatory names) or made to feel bad about oneself, being humiliated or belittled in front of other people, being threatened with loss of custody of one's children, being confined or isolated from family or friends, being threatened with harm to oneself or someone one cares about, repeated shouting, inducing fear through intimidating words or gestures, controlling behavior, and the destruction of possessions.

There are several contexts, dynamics, and factors that put key populations at risk for violence.

#### Violence at the place of work, cruising,

**or drug use:** This may include violence from managers, support staff, clients, or co-workers in establishments where sex work takes place (e.g., brothels, bars, hotels), or by other power structures at cruising sites for MSM, or violence from drug peddlers and pushers at drug sites for PWIDs.

#### Violence from intimate partners and family members: Stigmatization of key populations

41 NASCOP mapping estimates, 2013

42 UNAIDS. 2007. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS. [http://data.unaids.org/pub/Manual/2007/20070306\\_Prevention\\_Guidelines\\_Towards\\_Universal\\_Access\\_en.pdf](http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf)

43 Bates I et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part 1: determinants operating at individual and household level. *Lancet Infectious Diseases*. 2004; 4(5):267–277. doi:10.1016/S1473-3099(04)01002-3

44 Bates I et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part II: determinants operating at environmental and institutional level. *Lancet Infectious Diseases*. 2004; 4(6):368–75. doi:10.1016/S1473-3099(04)01047-3

45 UNAIDS. 2007. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS. [http://data.unaids.org/pub/Manual/2007/20070306\\_Prevention\\_Guidelines\\_Towards\\_Universal\\_Access\\_en.pdf](http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf)

46 WHO. 2005. Violence against sex workers and HIV prevention. Violence against Women and HIV/AIDS: Critical Intersections Information Bulletin Series, no. 3. WHO. <http://www.who.int/gender/documents/sexworkers.pdf?ua=1>

may lead partners or family members to think it acceptable to use violence to 'punish' a key population member who is engaged in sex work or in a same-sex relationship or takes drugs.

**Violence by perpetrators at large or in public spaces:** In most contexts, as the behaviors of key populations are not necessarily socially accepted and people use moral grounds to stigmatize, members of the general public often persecute key populations in the name of upholding moral values. Key populations may experience violence from landlords, boda boda drivers, religious leaders, etc.

**Organized non-state violence:** Key populations may face violence from extortion groups, gangs, and chokoras.

**State violence:** Key populations may face violence from law enforcement officers, like police or county askaris. Criminalization or punitive laws against key populations may provide cover for violence. Violence by representatives of the state compromises key populations' access to justice and police protection, and sends a message that such violence is not only acceptable but socially desirable.

### 1.3.1 Risk and Vulnerability among Sex Workers

HIV transmission risks faced by SWs include high volume of high-risk partners, inconsistent condom and lubricant use, and high prevalence of sexually transmitted infections and HIV positivity.<sup>47</sup> Common causes of vulnerability among SWs are poverty, stigma, harassment, violence, ignorance or misconceptions about HIV and STIs, and social and gender inequities. Such factors often weaken SWs' ability or determination to avoid coercive working environments, negotiate condom use, refuse sex with dangerous clients, and use health, social, and legal services, and thereby prevent or discourage SWs from protecting their health.

FSWs' risk and vulnerability are evident in findings of surveys among female sex workers in Kenya conducted by NASCOP in 2014.<sup>48</sup> Although most

FSW survey participants reported condom use during their most recent sex with a paying client (88%), about 36% reported at least one episode of unprotected sex with a paying client in the preceding one month. The most common reason for not using a condom, given by about a third of FSWs, was client refusal to use a condom, while about one in four FSWs reported that they had engaged in unprotected sex in the past month because of alcohol consumption or because of unavailability of condoms.

In the same survey, 22% of the FSW respondents reported being beaten or physically forced to have sexual intercourse in the past six months, and 44% of the respondents reported being arrested or beaten up by police/ askaris in last six months. The experience of violence increases an individual's risk and vulnerability to HIV.<sup>49</sup> Rape, coercion to have sex without condoms with law-enforcement personnel, and coercion to have sex without condoms in intimate relationships put sex workers at risk. In addition, fear of violence discourages sex workers from coming to places where commodities (condoms/needles) or preventive services are available, or forces them to disregard their safety during sex. Constant experience of violence also leads to anxiety, depression, loss of self-esteem, and neglect of their health, thus making sex workers vulnerable to HIV.<sup>50</sup>

Counterproductive legislation and policies increase FSWs' vulnerability by driving sex work underground, often into unsafe locations, thereby reducing the ability of law enforcement officers and health workers to protect sex workers' health and safety, and introducing the potential for police harassment. In the NASCOP Polling Booth Surveys in 2014, 32% FSW from Eldoret, 20% from Kisumu, 17% in Mombasa, 27% in Nairobi, 11% in Nakuru, 34% in Nyeri and 28% in Thika reported experiencing physical and sexual violence in the last 6 months. 44% of the FSW (aggregated across 7 sites) reported experiencing arrest or beatings by law enforcement in the last 6 months.

As illustrated in Figure 3, the risks and vulnerabilities faced by FSWs are influenced at the levels of society, community, and the individual.

47 Karnataka Health Promotion Trust. 2012. *A Systematic Approach to the Design and Scale-Up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers*. Bangalore: KHPT. <http://www.khpt.org/reports%20pdf/A%20Systematic%20Approach%20to%20the%20Design%20and%20Scale-Up%20of%20Targeted%20Interventions%20for%20HIV%20Prevention,%20full%20version.pdf>

48 Odek W et al. 2014. *Baseline Polling Booth Surveys among Male and Female Sex Workers in Nairobi and Mombasa NASCOP Learning Sites*. Nairobi: NASCOP.

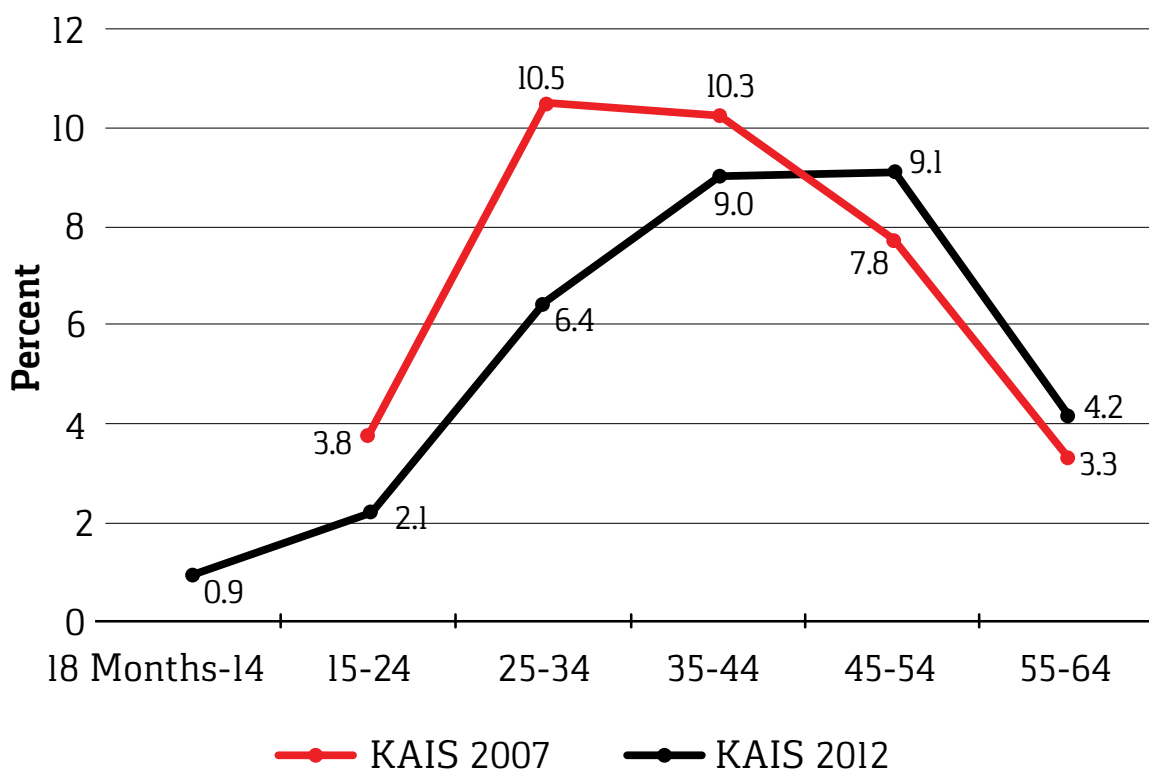
49 See Annex 2.11

50 WHO. 2005. *Violence against Sex Workers and HIV Prevention*. Violence against Women and HIV/AIDS: Critical Intersections Information Bulletin Series, no. 3. WHO. <http://www.who.int/gender/documents/sexworkers.pdf?ua=1>

Societal factors, including cultural norms, the economy, mass media, government policy, legal frameworks, women's rights, migration, trafficking, and stigmatization, set the context within which risk and vulnerability are formed. At the community level, factors include self-stigma, educational and employment opportunities, religion, alcohol and drug use, violence and crime, social services, and attitudes about sex work and

HIV/AIDS. At the individual level, contributing factors include demographics, length of time in sex work, knowledge and beliefs about HIV/AIDS, substance use, and expectations and aspirations for the future. The social organisation of sex work, including the solicitation process, work patterns, and venues, is influenced by the interaction of societal factors, the local sex work environment, and FSW characteristics.

Figure 3: **Risks and Vulnerabilities of FSWs**



The current paucity of local research on vulnerabilities specifically faced by transgender women (male-to-female transgender) hampers HIV-prevention programmes. A study of Hispanic and African American transgender women in the United States found that a key vulnerability for HIV/STIs was the social expression of transgender identity (measured as gender identity disclosure and dressing in female attire). Androphilic (*Androphiles - a subset of transgender women sexually attracted only to men*) sexual orientation, commercial sex partners (sex work), and the social expression of transgender identity were consistently associated with HIV infection.<sup>51</sup>

The study found that transgender women who live out their social lives in the female gender role from an early age and dress accordingly were more likely to become infected with HIV or some other STI. Because of dispositional factors or early socialization, some transgender women may have a greater need than others to express their gender identity at an early age. Once they are 'out' to others and live their lives in the female gender role they may become increasingly marginalized to a social realm where transgenderism is condoned and often desired (sex work). The study found that more than one-half of the transgender women among these populations reported a history of commercial sex clients. Further, due to difficulties in maintaining employment in the legitimate economy, transgender women may be financially compelled to pursue sex work, which then puts them at risk for HIV/STIs.<sup>52</sup>

Other studies have associated HIV/STI vulnerabilities with the following factors:

- Bi-gendered norms can complicate social integration. This complication combines with the effects of transphobia, including internalized transphobia, on access to employment, housing, healthcare, and social and economic inclusion. Social expressions of transgender identity may be psychologically beneficial in important respects, but 'coming out' to others may also expose gender-variant individuals to increased

abuse and discrimination and ultimately increase their odds of HIV/STI infections.

- Because of their failure to conform to conventional gender roles, transgender women may experience psychological and physical abuse, which is proclaimed to be a fundamental cause underlying many of the issues confronting gender variant individuals, including HIV infection.
- Lack of access to quality services by well-trained primary and allied health care providers who are knowledgeable about transgendered health and wellness
- Lack of access to affordable and accessible gender reassignment surgery or other surgeries
- Lack of access to unused needles that are the appropriate size for hormone injections

### 1.3.2 Risk and Vulnerability among Men Who Have Sex with Men

Men who have sex with men are another key population who experience risk and vulnerability to HIV and are therefore a strategically important group on which to focus HIV-prevention programming. High rates of HIV and STIs, low knowledge of HIV status, network risk, survivor guilt, low perception of risk, inconsistent and incorrect condom and lubricant use, unprotected sex with multiple concurrent partners of unknown HIV status, and poor health-seeking behaviour comprise the HIV transmission risks faced by MSM.

Surveys conducted by NASCOP in 2014 in five sites in Kenya found that

- 77% of MSM used a condom and only 54% of the MSM used lubricants in last anal sex
- 60% of the MSM penetrated/inserted into the partner during their most recent anal sex
- 61% of the MSM respondents also exchanged sex for money or goods with other men
- 57% of the respondents had a female regular partner and 64% of the MSM respondents also

<sup>51</sup> Nuttbrock L et al. Lifetime risk factors for HIV/STI infections among male-to-female transgender persons. *J Acquir Immune Defic Syndr*. 2009;52(3): 417–421. doi:10.1097/QAI.0b013e3181ab6ed8. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2784264/pdf/nihms-139784.pdf>

<sup>52</sup> Ibid.

had a regular male partner (who does not pay for sex)

- 31% of MSM had one occasion of unprotected sex in the past month
- 23% and 30% of the MSM respondents did not use a condom because the sexual partner did not want to use a condom or the partner had been drinking, respectively.

Stigma towards MSM, criminalization of anal sex, and the 'heteronormativity' of sexual health services discourage MSM from seeking medical services and disclosing their sexual behaviour and sexual health problems to health workers. Religious intolerance and homophobia—the fear of or antipathy against homosexuals—lead to social disapproval, marginalization, and persecution of MSM, increasing their vulnerability to HIV transmission. There have been numerous reports of hate crimes, including murder, against MSM. Studies of MSM in other African countries indicate that many MSM (43% among MSM surveyed in Senegal) have experienced at least one instance of rape.<sup>53</sup> Social rejection can exacerbate internalized homophobia and create psychological stress among MSM.<sup>54</sup> The NASCOP Polling Booth Survey study reported that 17% of MSM experienced beating and sexual harassment, while 24% of the respondents were arrested or beaten by police/askaris in the last six months.

### 1.3.3 Risk and Vulnerability among People Who Inject Drugs

A 2012 rapid situation assessment of the status of drug and substance abuse in Kenya revealed an increase in lifetime use of heroin among persons aged 15–65 years from 0.4% in 2007 to 0.7% in 2012.<sup>55</sup> Both the UNODC/ICHIRA RSA of PWID in Nairobi and Mombasa and the Population Council's Integrated Bio-Behavioural Survey (IBBS) conducted in 2011 revealed that 90% of PWID are

male. Almost all PWID inject drugs daily, with 75% injecting at least thrice per day. Between 33% and 50% of them have shared injecting equipment with close friends or primary sex partners.

Among PWID, HIV and other blood-borne infections, such as hepatitis B (HBV) and hepatitis C (HCV), are spread primarily through sharing of contaminated syringes and drug injection equipment. Although needles and syringes are sold by pharmacies, some pharmacy staff refuse to sell injecting equipment to people they suspect of abusing drugs.<sup>56</sup> Sharing of injecting equipment is common among drug users in Kenya, and evidence suggests that awareness is low regarding the risks associated with injecting.<sup>57</sup> The NASCOP PBS done with PWID found that 36% of PWID reported having an occasion in the past one month when they could not find a new needle. Seventeen per cent shared a needle with another person when they injected drugs the last time. Half the PWID had experienced a drug overdose. The survey also found overlapping risk. Nineteen per cent of female injecting drug users had sex with a paying client in the last one month. Similarly, 35% of the male PWID paid for sex in the last one month. Only 67% of the PWID used a condom when they bought or sold sex last time.

PWID serve as a potential epidemiological bridge for HIV transmission to other populations through unprotected sex with non-drug-using sexual partners, and through perinatal transmission to newborns.<sup>58</sup>

Of additional concern are the levels of violence and harassment experienced by PWID. On average, 31% of respondents in the UNODC/ICHIRA Rapid Situational Assessment (2012) had been confronted by police or other authorities in the past six months, and an assessment of female drug users in Malindi by the OMARI Project highlights widespread police extortion and non-existent legal representation. In the PBS conducted by NASCOP, 57% of the PWID report being arrested or beaten by police or askaris in the last six months.

53 NACC and Population Council. 2009. *The Overlooked Epidemic: Addressing HIV Prevention and Treatment among Men Who Have Sex with Men in sub-Saharan Africa*. Report of a consultation, Nairobi, Kenya, 14–15 May 2008. Nairobi: Population Council. [http://www.popcouncil.org/uploads/pdfs/HIV\\_KenyaMSMMeetingReport.pdf](http://www.popcouncil.org/uploads/pdfs/HIV_KenyaMSMMeetingReport.pdf)

54 Sharma A et al. Sexual identity and risk of HIV/STI among men who have sex with men in Nairobi. *Sex Transm Dis*. 2008;35(4):352–4. doi: 10.1097/OLQ.0b013e31815e6320. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2929353/pdf/dyq057.pdf>

55 National Authority for the Campaign against Alcohol and Drug Abuse (NACADA). 2012. *Rapid Situation Assessment of the Status of Drug and Substance Abuse in Kenya*, 2012. Nairobi: NACADA.

56 Beckerleg S, Telfer M, and Hundt GL. The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal*. 2005; 2(12) doi:10.1186/1477-7517-2-12. <http://www.harmreductionjournal.com/content/pdf/1477-7517-2-12.pdf>

57 Beckerleg S, Telfer M, and Hundt GL. The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal*. 2005; 2(12) doi:10.1186/1477-7517-2-12. <http://www.harmreductionjournal.com/content/pdf/1477-7517-2-12.pdf>

58 PEPFAR (The U.S. President's Emergency Plan for AIDS Relief). 2010. *Comprehensive HIV Prevention for People Who Inject Drugs, Revised Guidance*. <http://www.pepfar.gov/documents/organization/144970.pdf>

### 1.3.4 Overlapping Risks and Vulnerabilities

Many people from key populations compound their risk by engaging in more than one high-risk behaviour (e.g., injecting drugs and engaging in sex work, or a man who has sex with other men who also injects drugs). Thus, they are likely to have higher HIV prevalence rates than those with only one type of risk. Subgroups of key populations may have especially high risk for HIV infection.<sup>59</sup>

### 1.3.5 Adolescents and Young People from Key Populations

Studies are limited, but they consistently show that adolescents and young people from key populations are more vulnerable than older cohorts to STIs, HIV, and other sexual and reproductive health problems.<sup>60</sup> Rapid physical, emotional, and mental development; complex psychosocial and socio-economic factors; and poor access to and uptake of services increase their vulnerability and risk.<sup>61</sup> Particularly for those under 18 years of age, policy and legal barriers related to age of consent often prevent access to a range of health services, including HIV testing and counselling, and harm reduction and other services provided specifically for key populations. Such barriers also limit adolescents' ability to exercise their right to informed and independent decision making. Adolescents from key populations may face stigma, discrimination, and violence even greater than that faced by older people from key populations. Fearing discrimination and/or legal trouble, many adolescents from key populations are reluctant to attend diagnostic and treatment services. Consequently, they remain hidden from many essential health interventions, further perpetuating their exclusion.<sup>62</sup>

59 WHO. 2004. Evidence for Action: Effectiveness of Community-Based Outreach in Preventing HIV/AIDS among Injecting Drug Users. Geneva: WHO. [http://www.who.int/hiv/pub/prev\\_care/evidenceforactionreprint2004.pdf](http://www.who.int/hiv/pub/prev_care/evidenceforactionreprint2004.pdf).

60 Interagency Working Group on Key Populations. 2014. A background review of the global epidemiology among young people from key populations. Geneva: Interagency Working Group on Key Populations. Unpublished.

61 FHI. 2010. Young People Most at Risk of HIV: A Meeting Report and Discussion Paper from the Interagency Youth Working Group, U.S. Agency for International Development, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team on HIV and Young People, and FHI. Research Triangle Park, North Carolina: FHI. <http://www.unfpa.org/webdav/site/global/shared/iattp/docs/Young%20People%20Most%20at%20Risk%20of%20HIV.pdf>

62 WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

## 1.4 TYPOLOGIES

To guide HIV prevention efforts, programmers define typologies within each key population on the basis of common traits that present distinct levels of risk and vulnerability. These typologies are used by programmes to tailor prevention and outreach strategies specifically and appropriately for the risks and vulnerabilities associated with each typology, and to give priority to typologies that are most at risk and most vulnerable.<sup>63</sup>

### 1.4.1 Typologies of Female Sex Workers

In the past, female sex workers have been categorised according to various criteria, including practice, mode of operation, mode of organisation, nature of the sex work network, place of sex, primary place of solicitation, earnings, and level of autonomy from brothel owners. However, a categorization system should be clearly specified, with mutually exclusive and exhaustive categories that use directly measurable criteria and generally recognized definitions of FSW category. For the purposes of mapping and programme design, sex workers must be categorized according to their primary identity and terms of engagement in the sex trade.

One categorization system for sex workers is based on the types of places where they solicit clients, either directly or indirectly. By categorising sex work according to the place of solicitation, three key typologies have been identified that are applicable to FSWs in Kenyan urban and rural settings: 1) public/street-based sex work, 2) home-based sex work, and 3) venue-based sex work.

#### Public/Street-Based Sex Work

Public/street-based sex workers tend to work in the evenings and solicit and pick up clients in streets and public places /parks, whereas beach-based sex workers tend to ply lake/ sea shores during the day. Solicitation generally occurs directly by the sex

63 Karnataka Health Promotion Trust. 2012. A Systematic Approach to the Design and Scale-Up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers. Bangalore: KHPT. <http://www.khpt.org/reports%20pdf/A%20Systematic%20Approach%20to%20the%20Design%20and%20Scale-Up%20of%20Targeted%20Interventions%20for%20HIV%20Prevention,%20full%20version.pdf>

worker, though in some instances it occurs through pimps and brokers in the same public spaces. Taxi drivers or bar owners may facilitate access to such sex workers, but most operate independently. Sexual services typically occur in places that are known to the sex worker or client, such as lodges, brothels, uninhabited buildings, the home of the client, on the streets, in car parks, and other public spaces. After venue-based sex work, public/street-based sex work constitutes the second most common typology of sex work in Kenya.<sup>64</sup> Public/street-based sex workers are highly vulnerable to assault and crime.

### Home-Based Sex Work

Home-based sex workers typically operate from their homes. They can directly control how they perform sex work, including the choice of clients and payments. Clients are contacted through word of mouth, middle men and through referrals from other sex workers. Sex typically occurs in the home when co-habiting partners are away or in the home or lodge of the client's choice. Emerging trends indicate that home-based sex work is prevalent in rural settings while in urban settings this type of sex work takes place predominantly in slum areas. Home based sex workers are considered the most hidden and may be the most difficult to reach through outreach.

### Venue-Based Sex Work

Venue-based sex work is the primary type of sex work in Kenya. Venue-based sex workers solicit in brothels, bars, bars with attached lodging, strip clubs / night clubs, and massage parlours.

**Brothel-based sex workers** operate from brothels (recognized or hidden) or **sex dens** (similar to brothels but un-regulated) and clients are arranged through the brothel managers or madams who receive a portion of the earnings. Typically, a small group of sex workers will work out of one brothel and have little or no control over the choice of clients. Sex occurs in the brothel or at an alternative location of the client's choice, such as a lodge or at his home.

Other venues in which sex is exchanged for money may be further classified as follows:

**Bars** (without lodging) where men go to drink and pick up sex workers. These venues include registered/licensed facilities and drinking dens in commercial, urban, peri-urban, rural, and slum settings.

**Bars with lodging** (bars which have adjacent boarding facilities) are establishments where men will go to drink and pick up either bar hostesses who may also trade in sex or sex workers who ply the location, with whom they will retire to an adjoining room for sex. Taxi drivers and bar and hotel owners usually facilitate the sex worker-client interaction and may or may not receive a portion of the sex worker's earnings. In **the rural context**, bars may translate to local brew dens where the proprietors and staff facilitate the sex worker-client interaction and may or may not receive a portion of the sex workers' earnings.

**Strip clubs / night clubs** are where men may pick up strippers who also trade in sex or sex workers who frequent the clubs, and retreat to an alternative location for sex. These are clubs or bars where close, erotic dance occurs. Although management discourages physical contact, it is possible that sex may be negotiated in some lap dancing bars.

**Massage parlours** whose range of services may include paid sexual services. In rural settings these may translate into hair and beauty salons and barber shops. Proprietors or personnel may facilitate the sex worker-client interaction and may or may not receive a portion of the sex workers' earnings.

### Others – Online Networks

In addition to the specific sex work typologies noted above, there are a number of others that can be found in different settings, such as **escort services**. This is the most discreet type of sex work. The client usually contacts an escort (i.e., sex worker) by calling a listed phone number through a contact, hotel staff, or online. Services are provided at the clients home or hotel room. Escort services are usually run by a management team that requires a certain percentage of the money sex workers receive from clients.

The typologies used here are often overlapping and fluid. For example, a sex worker may be street

64 Odek WO et al. Estimating the size of the female sex worker population in Kenya to inform HIV prevention programming. *PLoS ONE* 2014; 9(3): e89180. doi:10.1371/journal.pone.0089180. <http://www.plosone.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0089180&representation=PDF>

based for some time and then go into a contract with a lodge owner to become lodge based. Or a brothel-based sex worker may move to another town or city temporarily and work as a street based sex worker.

### 1.4.2 Typologies of Male Sex Workers

In a mapping exercise carried out by NASCOP, MSM and male sex workers (MSWs) were grouped according to their location of congregation (including popular venues, the streets, home-based, and escort services). However, like MSM, MSWs are typologised according to their sexual behaviour. More research is needed in Kenya to identify and profile MSM typologies and to learn the proportions of MSM who are at higher risk and those among the group who are MSW.

**Typologies of Men Who Have Sex with Men**  
**For operational and programming purposes, the following typologies\* will apply:**

**Top** - Refers to men who penetrate their partner during penile anal sex.

**Bottom** - Refers to men who are penetrated during penile anal sex.

**Versatile** - Refers to males who are both insertive and receptive during penile anal sex.

**NB** \*While it is important to know whether men prefer to be bottoms or tops or versatile, health service providers should make sure that men understand the risk of unprotected receptive anal

intercourse and avoid asking private questions about which sexual roles people prefer.

### Identities, Contexts, and Practices

**Men with non-heterosexual identity** (gay, homosexual, bisexual, or other culture-specific concepts that equate with attraction to other men)

**Men who consider themselves heterosexual but who engage in sex with other males** for reasons like isolation, economic compensation, sexual desire, and gender scripts.

**Settings with forced gender segregation**, such as prisons and military establishments, are important contexts for male-to-male sexual activity not linked to homosexual identity.

**Sex between men** includes anal sex, oral sex, mutual masturbation, or any combination of these practices.

Many MSM conceal their sexual preference because of societal expectations, and publicly conform to patriarchal norms due to fear of discrimination, arrest, or violence.



# Operationalising Combination Prevention Interventions for Key Populations

## CONTENTS

*Chapter 2 presents the contextual ‘what’ and ‘how’ with regards to operationalising combination prevention for key populations.*

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# 2.1

## INTRODUCTION

HIV-prevention programming begins with mapping. Mapping is done to learn where and on what scale to intervene and to estimate the resources that intervention will require. Using data from mapping, implementing organisations can plan how best to reach and serve the key population. Macro-planning locates service providers and establishes service outlets in areas that have large concentrations of key populations. Key population peer educators are recruited and trained to use micro-planning for peer-led outreach. Implementing organisations then launch combination prevention interventions that reduce people's HIV risk through biomedical services and behaviour change, and that reduce their vulnerability by creating an enabling environment for HIV prevention.

# 2.2

## UNDERTAKING MAPPING AND SIZE ESTIMATES

**Mapping of key populations and population size estimates** are necessary to start a programme, for budget and programme planning, and for deciding how many services to place, and where. Size estimates are also essential for estimating levels of coverage, using data on key populations' contact with fixed-site or outreach services. Site-based size estimates, rather than country- or province-based estimates, are crucial to developing a programme, as they help implementing organisations develop site-based intervention plans. The size estimates are updated periodically using programme data, and remapping may be

done if social, political, or economic forces lead to significant changes in the sex worker population.

**Note:** Maps and other data containing information about key populations (e.g., location, type of sex work practised) should be considered confidential and stored securely at a central location, such as a safe space (drop-in centre). Programme planners and implementing organisations should guard against the possibility of maps being obtained by law enforcement authorities or other groups who might use them to locate and close sites or otherwise cause harm to key populations. If these confidential materials are disclosed, it is likely that the programme will lose the trust of the community

Mapping methodologies are premised on the understanding that key populations congregate in definable geographic locations. Accordingly, mapping focuses on identifying these locations, characterizing specific 'hot spots' therein, determining how and where high-risk activities occur, and estimating the number and size of key populations that frequent the locations and hot spots. This information is then used to define and prioritize locations where programme coverage should be saturated and inform the appropriate and adequate delivery of combination prevention services.

Mapping and size estimation is a multi-stage process, focusing increasingly on local levels to refine the information and make it more accurate. Mapping should always be done discreetly so as not to draw undue attention to the activity. Mapping is done in three stages (see Box: Three Stages of Mapping).<sup>65</sup>

65 WHO et al. 2013. *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

## Three Stages of Mapping

### First stage: 'Where in the county can one find significant numbers of key populations?'

To determine where services should be established, a central-level planner must first understand where key populations are located. This information may be obtained by interviewing key informants like boda boda drivers, taxi drivers, lodge owners, health providers, and representatives of industries that attract a large number of male workers (extraction, construction, seasonal agriculture, etc.), drug peddlers or pushers. An approximate number of key populations should be obtained for each identified area in order to focus interventions initially on the locations with the largest number. Please note that the key informants for mapping sex workers will be different from those who one will interview to find out about PWIDs.

### Second stage: 'How many key populations are in these locations/spots?'

Once the general geographic area is known, more detailed mapping

and size estimation may be done.

• **First phase:** Local key informants (police, taxi drivers, NGO workers, truckers) are interviewed to identify where sex workers meet clients, where MSM congregate, or where PWID inject drugs. Key populations who are willing to assist may also be recruited to help list these spots.

• **Second phase:** Locations/spots identified by multiple informants are investigated further. Detailed information is sought from key populations in these spots on the number of specific key population subgroups by time of day, specific places where key populations gather, and additional areas near the location where other KPs may be found. (The purpose of asking for additional locations is to find any unknown sites not identified by key informants in the first phase.)

Depending on the availability of an implementing partner in the area, the findings may be validated by presenting and discussing them with the implementing partners

and the peer educators in the organisation.

Maps showing local landmarks and hot spots may be prepared, either on paper or using electronic equipment, such as global positioning systems (GPS) or geographic information systems (GIS). The programme uses this information in close consultation with the key populations to decide where service points, such as safe spaces (drop-in centres) and clinics, should be located. Other clinics may be listed and mapped to establish referral relationships. The programme design is further refined and informed by key populations who describe the locations, hours, habits, and other information that will determine when, where, and how services are set up.

### Third stage: 'Who are the sex workers and what is their risk and vulnerability?'

In this stage, contact listing is done to identify precisely who may be reached by individual peer educators to further inform local planning, while including the key populations.

At the national level, key population mapping and size estimates can be used to

- prioritise the counties and locations in the counties where interventions should be prioritised
- plan and allocate resources for programmes based on the number of key populations.

At the implementation level, mapping and size estimation help programme implementers/donors to

- identify locations which are hot spots and prioritise them based on estimates
- estimate the size of key populations in each hot spot, by typology, and determine personnel needs for adequate interventions

- begin the process of mobilising key populations for HIV/STI prevention interventions to

- ▶ raise awareness of HIV
- ▶ increase knowledge about risk reduction strategies
- ▶ increase knowledge about existing HIV/STI prevention interventions for key populations
- ▶ explore safe and private spaces for key populations to meet and work together
- ▶ build social capital and solidarity (a collective voice) among key populations
- ▶ build a core group of key population members from the hot spots who will serve as an important resource for project implementation by recruiting and training local key population members to support mapping and site assessments.

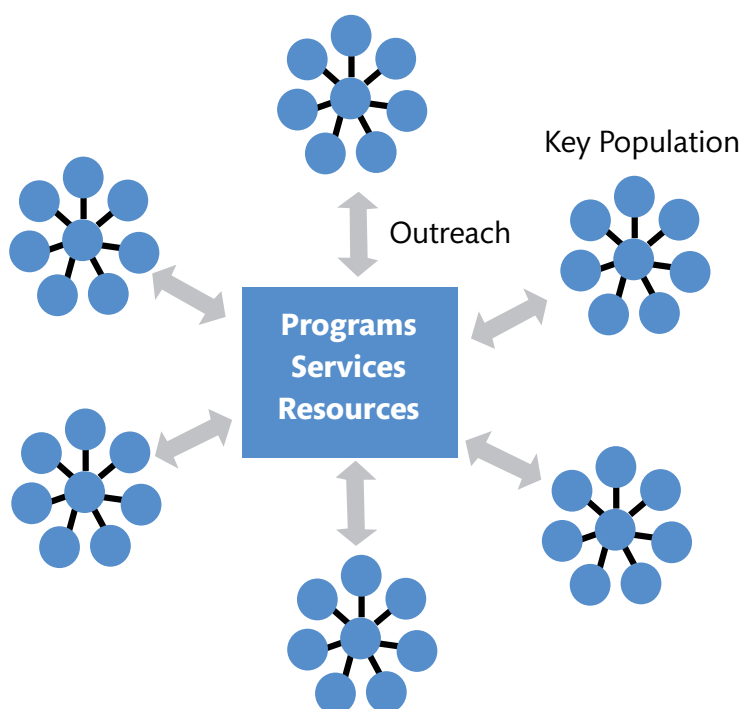
## 2.3

### PEER-LED OUTREACH

Outreach entails actively delivering information, products, and services to existing or potential service users in locations where they typically spend time, rather than relying on them to come to programme sites. Outreach is documented as it occurs, and these records are analysed to plan outreach and to monitor and assess programme implementation and performance.

Outreach thus serves as a two-way channel that delivers HIV-prevention essentials to key populations while simultaneously providing implementers and public health authorities with information that is used at multiple levels for programme management.

Figure 4: **Outreach Model**



### Outreach

- makes contact with people involved in sex work and or injecting drug use<sup>66, 67</sup>
- makes contact with vulnerable populations who are new to an environment and hence may be unaware of local programmes and services
- identifies key population needs and concerns
- sustains on-going relationships with key populations to ensure they have access to and use services
- delivers information and health, harm-reduction, and other products/services
- advertises and promotes wider services offered by a project
- provides referrals to other services
- creates peer support for sustaining behaviour change
- uses innovative outreach strategies (e.g., involving influential persons as champions or ambassadors for the cause) to reach key populations (KPs) outside of main networks, such as students in sex work and people residing in hot spots

A key aspect of outreach is adapting services and making them more accessible, appropriate, and flexible by taking them directly to the service user.

The core **objectives of outreach** are to

- Build rapport and trust with key populations and foster a sense of solidarity and support
  - ▶ Identify groups/individuals at risk
  - ▶ Establish rapport and build confidence between the community and the project
  - ▶ Provide information about HIV prevention and available services
- Mobilize and support vulnerable communities
  - ▶ Establish and strengthen mutual peer support

- ▶ Identify and support local community leaders
- ▶ Manage crises
- Directly provide the means for prevention
  - ▶ Educate and empower communities for risk reduction
  - ▶ Directly provide preventive commodities (e.g., clean injecting equipment, condoms)
- Provide counselling
- Provide referrals to behavioural and biomedical interventions
- Provide interventions that reduce both risk and vulnerability

### Guiding Principles of Outreach

**Respect for the Community**, wherein FSWs, MSM, MSWs, TG, and PWID are valued as individuals with rights to confidentiality, dignity, and a safe and secure life and work environment.

**Team Work** that bridges gaps between project staff, service providers, and community by building relationships of mutual respect, trust, acceptance, and learning and delivery of quality outreach services.

**Self-Representation/Empowerment** that builds capacities of community members as leaders, participants, and owners of HIV-prevention programmes.

The provision of outreach to key populations requires a strong peer network. A drop-in centre providing a safe environment, information, condoms, and clean injecting equipment along with STI management and referral services is also important.

## 2.3.1 Outreach to Female Sex Workers

Outreach with female sex workers should happen primarily in the hot spots / client soliciting sites. In some cases, outreach may be conducted with sex workers in non-hot-spot-based sites, but only after the peer educator obtains the sex worker's

<sup>66</sup> Hester M and Westmarland N. 2004. *Tackling Street Prostitution: Towards a Holistic Approach*. Home Office Research Study 279. London: Home Office Research, Development and Statistics Directorate. <http://dro.dur.ac.uk/2557/1/2557.pdf>

<sup>67</sup> Hunter G, May T, and Drug Strategy Directorate. 2004. *Solutions and Strategies: Drugs Problems and Street Sex Markets, Guidance for Partnerships and Providers*. www.drugs.gov.uk. London: Home Office. <http://www.vawpreventionscotland.org.uk/sites/default/files/Drug%20Problems%20and%20Street%20Sex%20Markets.pdf>

consent. For venue-based hot spots, it is best that peer educators reach out to sex workers in their work hot spots, especially those who come from distant places to practice sex work. Meeting in the venue gives peer educators and other outreach staff first-hand understanding of the places the FSWs operate from, their needs, and associated vulnerabilities. It is important to build rapport and trust with managers/owners of these venues to ensure that FSWs are accessible and, more importantly, to arrange for FSWs to get services directly within these venues. Outreach to home-based FSWs should happen discreetly in a place approved by the FSWs.

Age is an important consideration for outreach programme design, as younger FSWs have different concerns and needs than those who are older. For example, those who are younger may be concerned with family planning, maintaining their physical appearance, and maximizing their client load. Older FSWs may be more concerned with finding economic alternatives and protecting their children.

When planning outreach, FSWs' daily routine should be considered to ensure feasibility of service uptake. Outreach targeting street-based/public sex workers should occur during solicitation times and should include prevention messages and condom distribution. Outreach targeting home-based sex workers should occur during off-peak times and should be delivered discreetly to minimize possible exposure in the neighbourhood. Outreach targeting brothel-based sex workers should occur during off-peak times and requires rapport with brothel managers and madams.

The impact and influence that third parties, such as family members, community leaders, pimps, and bar managers, have on the lives of FSWs should also be considered. These third parties may be able to promote condom use and service referral, and protect women from harassment and violence.

When sex work occurs clandestinely in public environments such as bars, clubs, and pubs, and during specific fetish/themed evenings, sex workers may not be easily identifiable. In such settings a community development approach to outreach is useful, with projects introducing themselves to bar staff, owners, and managers.

### 2.3.2 Outreach to Men Who Have Sex with Men

The priorities, needs, and attitudes towards health-seeking behaviour among the MSM, MSW, and TG communities vary from those of the FSW community. When designing an outreach for them, it is important that programmers and peer educators address their needs related to STI/HIV services, condoms, and lubricants and issues related to identity and gender. Also it is important to treat the MSM, MSW, and TG communities as heterogeneous and to respect that heterogeneity. For programming purposes, while it is important to know who are generally bottoms or tops and versatile, health service providers should focus on the risk of unprotected receptive anal intercourse and avoid asking private questions about which sexual roles people play.

### 2.3.3 Outreach to Transgender Women

Before they enter the doors of a service provider, transgender people must see evidence that the programme has taken proactive steps to learn how to appropriately serve transgender people.<sup>68</sup> A single insensitive remark or lack of capacity to address their needs can send a transgender client out the door, never to return. Prior to making formal outreach efforts to the transgender community, it is critical that service providers assess their own readiness and capacity.

Thereafter, the first step in reaching transgender women in the community is to locate their meeting and communication venues. After determining where transgender people congregate and find support, it is advisable to contact these organisations either in person or by letter, phone, or e-mail. Some transgender people are so aware of the potential for anti-transgender violence or discrimination that they may be reluctant to discuss transgender topics in public places. Similarly, some transgender individuals simply prefer more privacy regarding their transgender status or history.

In Kenya, the transgender community prefers not to be referred to or clustered with persons of

<sup>68</sup> Office for Victims of Crime. 2014. *Outreach: Connecting to the Transgender Community*. [http://ovc.gov/pubs/forge/tips\\_outreach.html](http://ovc.gov/pubs/forge/tips_outreach.html)

different sexual identity (MSM, gay, or lesbian). They consider their identity, health needs, and social concerns as distinct and may take offence at poor referencing. Service providers should avoid the use of pronouns like 'she' or 'he', and when addressing a mixed audience it is important to steer clear from gendered words. It is safest to make reference to 'people', 'individuals', and 'human beings', not 'men and women.' When with transgender persons, it is advisable to politely ask them what pronoun to use to address them.

### 2.3.4 Outreach to People Who Inject Drugs

Needle and syringe programmes provided through outreach increase access to clean injecting equipment, condoms, and information about safer sexual and injecting practices for people who use drugs and for their sexual partners.<sup>69</sup> To be effective, projects need to appoint people who use drugs as peer educators and outreach workers and also consult and involve them during the situation assessment, planning, implementation, and evaluation of the intervention.

<sup>69</sup> International HIV/AIDS Alliance & Community Action on Harm Reduction. 2012. *Reaching Drug Users: A Toolkit for Outreach Services*. Hove, UK: International HIV/AIDS Alliance. [http://www.aidsalliance.org/assets/000/000/380/90629-Reaching-drug-users-A-toolkit-for-outreach-services\\_original.pdf?1405520658](http://www.aidsalliance.org/assets/000/000/380/90629-Reaching-drug-users-A-toolkit-for-outreach-services_original.pdf?1405520658)

### Key Considerations for Outreach: Barriers, Proximity, and Risk

- Barriers to prevention services should be identified and addressed by outreach.
- Proximity is also an important consideration when planning outreach services, as outreach should be implemented in each location and site where sex work takes place or key populations congregate, with attention given to the specific characteristics and needs in different contexts.
- Key populations who are more at risk of HIV transmission because of higher client/ partner/ injecting loads require prioritization over those with lower client/partner/injecting loads.

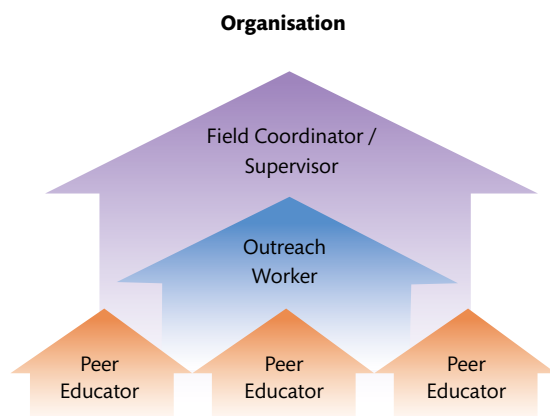
Robust outreach is responsive to two perspectives; that of the programme and that of the community being reached by the programme, as demonstrated by the questions in Figure 5.

Figure 5: **Programme and Community Perspectives on Outreach**

|                            | Program Delivery Perspective         | Program Delivery Perspective          |
|----------------------------|--------------------------------------|---------------------------------------|
| Basic Outreach             | "How many people did I reach?"       | "Was I reached?"                      |
| Establish Rapport          | "Have I established rapport?"        | "Do I trust this person and program?" |
| Service links and delivery | "Did I provide programs / services?" | "Are those services suitable for me?" |
| Prevention Education       | "Have I educated about prevention?"  | "How will I reduce my risk?"          |

Outreach planning is undertaken at all levels of programming. Figure 6 portrays outreach planning in an organisational context.

Figure 6: **Outreach Team Structure**



Outreach planning tools (listed in Table 1) facilitate a peer educator's individual-level planning and follow-up of her or his work, based on the individual risk and vulnerability profiles of key population members and their sexual partners. By giving a visual picture of the site that a peer educator is managing, these tools help the peer educator understand the extent to which programme services have reached key populations, and identify and monitor problem areas.

**The benefits of outreach planning include**

- individual tracking
- repeat visits for monthly screening
- ability to collect, analyse, and act upon data
- peer educator's site management creates and strengthens community ownership
- shift from push to pull in services
- defined area of operation

Table 1 provides a summary of outreach planning tools (described further in Annex 2.2.1–2.2.5).

Table 1: **Outreach Planning Tools (Summary)**

| Tool                     | Objective                                                             | Purpose                                                         |
|--------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| Spot analysis            | Prioritise spots for outreach                                         | Improve quality of outreach                                     |
| Contact listing          | Develop a unique list of key populations in the spots                 |                                                                 |
| Site load mapping        | Prioritise outreach to the spots                                      |                                                                 |
| Peer plan                | Reach all key populations in the peer list on a regular basis         | Build peer educator capacity to monitor his/her own performance |
| Opportunity gap analysis | Understand gaps in reach and service uptake among the key populations | Improve service levels and continuously improve programming     |

## 2.4

### IMPLEMENTING OUTREACH

The first step in outreach is recruitment of peer educators. Peer educators are members of a key population who are trained to conduct programme outreach to their peers.

Peer educators are best qualified and situated to establish regular contact with key population members. However, regardless of the peer educator's level of social agency, it is important to respect privacy when carrying out outreach; ensuring that recipients feel that can safely confide in the peer educator.

#### Useful tips<sup>70</sup> on making initial contact

- Explain who you are and what you want.
- Emphasise the confidentiality of the project.
- Reassure key population recipients that you are not police or journalists.
- Do not expect recipients to fill in questionnaires on first contact or to give any details for some time (some people may choose not to at any point).
- If the recipient is a sex worker, do not interfere with business, wait until the individual is free.
- Immediately offer of condoms.
- Give a card with your name and the project's name and phone number.
- Have an official identity card available to show if requested, and/or give the name and phone number of someone who can confirm your identity.
- Be patient—building trusting relationships takes time.
- Be persistent.
- Be honest—know your limitations.
- If the recipient is transgendered, ask what pronoun to use to address them.

Projects also need to learn how to relate to the people/gatekeepers around key populations. For example, with regard to sex work in lodges, receptionists and managers are key influencers. On the street, partners of sex workers may be around in some areas. Outreach workers should not

collude with or be hostile to gatekeepers or intrude on their privacy.<sup>71</sup>

The frequency of outreach will be guided by factors such as the size of the area and the number and typology of key population individuals within that area.

Also, local conditions can change. For example, new peers may move into the area and operate at different hours or in as-yet unmapped areas. It is good practice to review the service to see whether it is available at the right times and is reaching the right key populations. Programme reviews should include consultation with service users.

**The mapping exercise will have determined the presence of other local projects running outreach services. Implementing partners within the same geographic location should consult with each other and discuss local needs, coordinate outreach times, and avoid replication/duplication.** Coordination, communication, and joint work mean less fragmentation and confusion for service users and more reliable programme data collection and reporting. Implementing partners should also gather feedback about street dynamics, such as problematic areas, people, cultures, and population. This will facilitate optimum programming.

## 2.5

### MACRO-PLANNING AND MICRO-PLANNING FOR PROGRAMME COVERAGE

Designing appropriate, large-scale HIV-prevention programmes targeting key populations requires a) documenting the size and distribution of the population, b) identifying and characterizing key population locations, and c) planning appropriate service provision.

**For the purposes of this guideline, the term 'scaling-up' refers to increasing the coverage of essential services in an HIV-prevention programme for key populations.**

<sup>70</sup> European Network for HIV/STD Prevention in Prostitution (EUROPAP/TAMPEP). 1998. Hustling for Health: Developing Services for Sex Workers in Europe. EUROPAP/TAMPEP. [http://tampep.eu/documents/hustling\\_for\\_healthEN\\_1998.pdf](http://tampep.eu/documents/hustling_for_healthEN_1998.pdf)

<sup>71</sup> Overs C and Hunter A. 1997. Making Sex Work Safe. Edinburgh: Global Network of Sex Work Projects (NSWP). [http://www.nswp.org/sites/nswp.org/files/Making%20Sex%20Work%20Safe\\_final%20v3.pdf](http://www.nswp.org/sites/nswp.org/files/Making%20Sex%20Work%20Safe_final%20v3.pdf)

**‘Coverage’ is defined as the proportion of the key population that receive a defined set of services that address their risks and vulnerabilities. Achieving high coverage depends on two levels of planning: macro- and micro-planning.**

**Macro-planning** is the use of national or regional epidemiological data to map an epidemic’s distribution and to inventory and map disease control measures in order to assess the adequacy of disease control efforts and thereby determine where and among which populations intervention should be started, increased, or modified. The goal of macro-planning is to achieve and maintain intervention coverage of at least 80% of key populations at the national or regional level.

**Micro-planning** is individual-level outreach and service delivery planning that is informed by visiting hot spots where key populations are concentrated and collecting information about high-risk behaviour of each individual in these spots. The goal of micro-planning is to achieve and maintain intervention coverage of 100% of key populations within every targeted hot spot.

**The goal of macro-planning is to rapidly establish appropriate outreach programmes and basic services in locations that contain a high concentration of key populations.**

The techniques used for macro-planning are scalable and can be applied at multiple administrative levels to make coherent allocation decisions between different regions. The particular geographic divisions within which macro-planning can occur depend on the objectives and the geographic boundaries within which the relevant administrative and resource allocation decisions are made. In general, when developing a new programme or scaling up an existing programme, regions should be selected based on feasibility of programme implementation. In Kenya, it is appropriate to work at the national and county levels because these are generally where planning occurs. It is important not to lose the larger picture and interconnectedness of specific sites by focusing only at a very local level.

In addition to identifying key population locations and quantifying key populations, mapping results can be used to identify the presence of existing programmes and services.

### 2.5.1 Macro-Planning

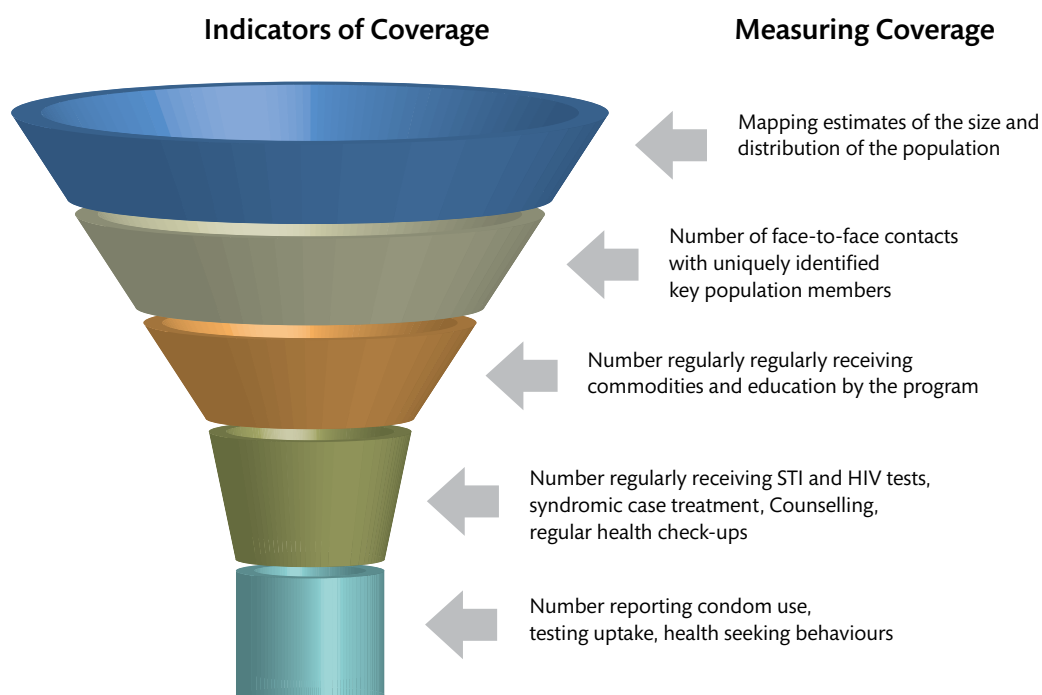
Macro-planning involves the evidence-based selection of geographic regions requiring services, and then mapping those regions to identify the area or areas with the highest densities of key populations. Next, the size and characteristics of the key population should be identified and the local context described, which includes listing the existing relevant service providers. The needs, service gaps, and best configuration of services should be determined, and partnerships formed with existing or new service providers to deliver these services.

Advocacy with and involvement of key populations, stakeholders, and power structures are crucial. As the goal of macro-planning is to establish appropriate services in optimal locations, high-level programme monitoring can identify the ‘opportunity gaps’, defined as the number of service users who have not received or are not currently receiving key outreach and service delivery programme components.

As the basic **concept of ‘scaling up’** involves increasing the proportion of the target population receiving a defined set of programmes and services, mapping is key to determine the target population size and locations. Denominators, which specify the size of the target population, are essential for setting goals and assessing programme coverage.

To illustrate the interaction of the key indicators used to measure programme coverage, a funnel is an appropriate model (Figure 7). The funnel illustrates that each successive stage of programme engagement requires engagement at the previous stage.

Figure 7: **Programme Coverage Funnel**

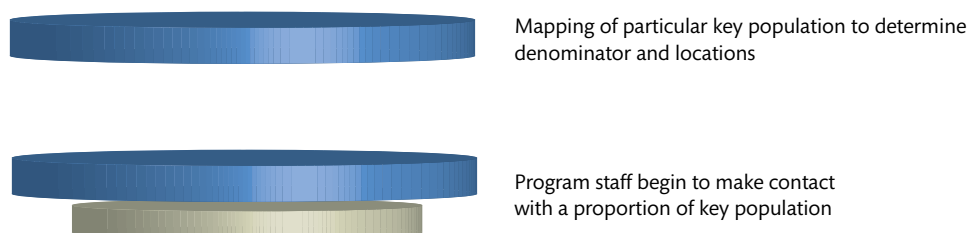


At the initial stages of planning, once the population has been mapped, the funnel will be broad at the top. As outreach and service components are added to the programme, and the key populations begin to engage with the programme, the distal part of the funnel will begin to expand. **Achievement of 100% programme coverage would result in funnel expansion to the shape of a cylinder.**

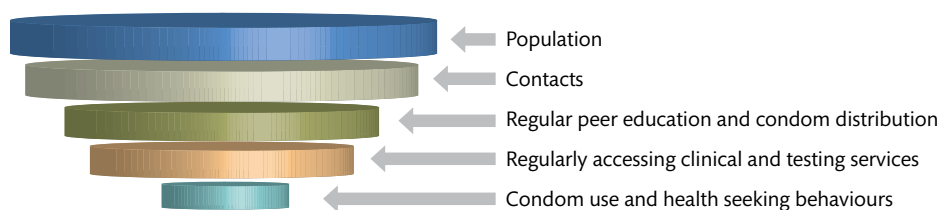
However, while the goal may be for key populations to be involved in all successive stages of programme engagement; this may not occur

evenly. For example, key populations who are not accessing programme services may engage in more health-seeking behaviours as social norms change and information from the programme spreads by word of mouth. Additionally, key populations who are accessing programme services may not regularly receive education, but may regularly access testing. Over time, as new individuals join the community, more service users than the number originally mapped may be found to be accessing the programmes and services (Figure 8).

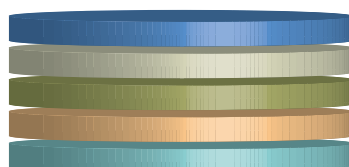
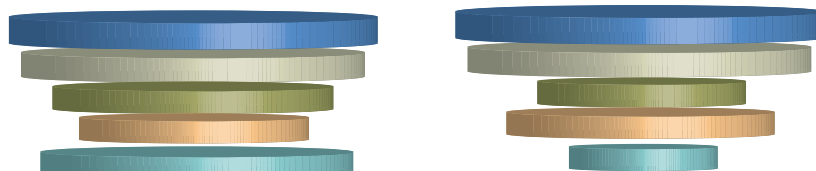
Figure 8: **Measuring Programme Coverage at Different Levels of Key Population Engagement**



As other aspects of the programs are implemented, the proportion of the key population involved with each state of program engagement increases



Uneven engagement in program services, e.g. peers who are accessing program services may not regularly receive education, but may regularly access testing



The goal is to reach 100% program coverage, where 100% of key populations are reached at all levels of program engagement

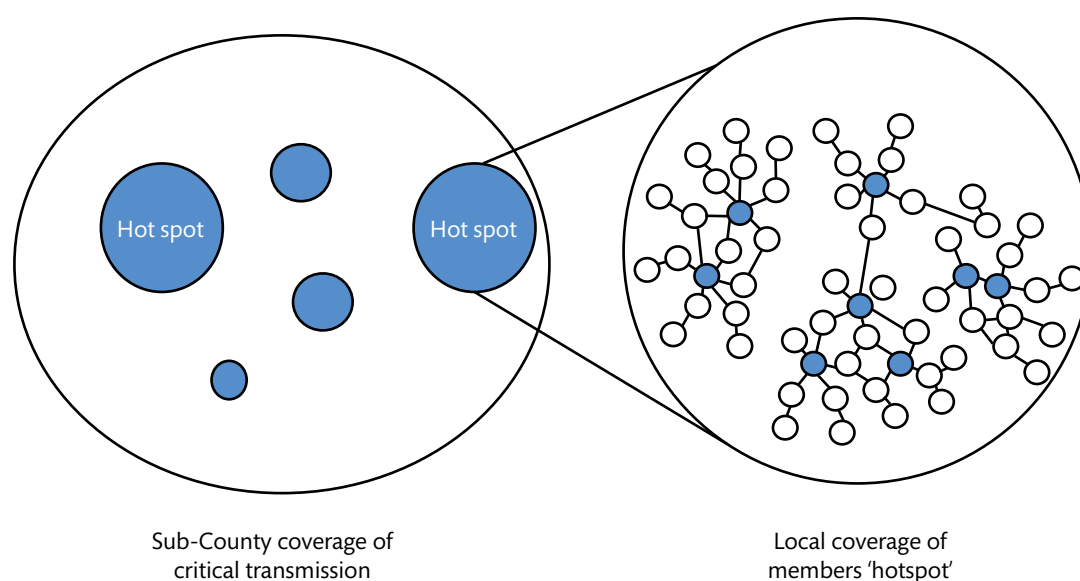
Macro- and micro-planning and implementation can occur in tandem (Table 2). While programmes are being established at the macro-level, ensuring that all major sites are covered and service providers have been identified and secured, at the micro-level the community is involved in validating sex work sites that were identified during mapping, identifying peer educators, and exploring networks.

## 2.5.2 Micro-Planning

The second step in outreach, micro-planning, has been developed on the premise that each hot spot and each key population member in every hot spot has different risks and needs. The programme team should be able to recognize this differential need and design a programme prioritising the needs and risks. Hence micro-planning involves the identification and/or validation of specific locations (hot spots) within the larger region where key populations operate (mainly discovered during mapping) and the collection of more in-depth information about high-risk practices in those locations.

**TABLE 2: Macro- and Micro-Planning, Implementation, and Scale-Up**

|                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Use existing knowledge and data to identify a region of high HIV prevalence in need of prevention activities.                                                                                         |
| Identify the categories of high-risk populations for HIV transmission that exist within that area (using existing and new knowledge and data).                                                        |
| Perform comprehensive mapping to determine the size and distribution of key populations within the region and to estimate the proportion not being reached by existing local programmes and services. |
| Identify hot spots that together constitute an estimated 80% of the key population.                                                                                                                   |
| Establish programmes and services in the hot spot areas, in collaboration with existing programmes and services.                                                                                      |
| Plan and implement outreach and service delivery to cover a high proportion of the key population individuals within each hot spot.                                                                   |
| Perform peer-led mapping to validate and define locations of high-risk activity.                                                                                                                      |
| Perform spot profiling of high-risk activity.                                                                                                                                                         |
| Perform peer social network analysis to determine which peer educator will take responsibility for outreach to each individual member of the key population.                                          |
| Continuously measure and monitor opportunity gaps, defined as the proportion of the key population that has not yet received key outreach and service delivery programme components.                  |
| Design and implement a high-level programme evaluation strategy that captures programmatically relevant indicators and distal outcomes.                                                               |

FIGURE 9: **Determining Coverage**

*Adapted from AIDS in South Asia: Understanding and Responding (World Bank 2006)*

**Micro-planning also includes detailed service implementation planning, service provision, and routine evaluation. At the micro-level, achieving 100% coverage within specific sites is the goal.** Achieving this high coverage depends on placing programmes and services in hot spots, defined as the geographic areas that contain a high proportion of the target population. Hot spots have (or have the potential for) higher levels of HIV transmission compared to other areas because of the characteristics of the sexual structure and transmission dynamics of HIV. Appropriate and effective planning and implementation of outreach and service delivery to reach a high proportion of the key populations within hot spots are essential (Figure 9).

Implementation of the micro-plan should be informed by the geographic distribution of key populations, the number of key populations and their volume of sex work/partner turnovers/ injecting episodes, type of sex, typologies of key populations in that location, age of key populations, time considerations, and other stakeholders involved in the lives of key populations. The barriers to accessing prevention services will be considered and addressed by outreach.

- **Geography** is an important consideration when planning outreach services, as outreach should

be implemented in each location and hot spot where sex work/injecting episodes takes place, with attention given to the specific characteristics and needs in different contexts. For example, the bar-based hot spots in cities operate mostly after 4 pm and get very active after 7 pm in the evening. Hence the outreach in those sites will be done in the evening rather than in the morning.

- **Volume of sex** is relevant, as high-volume (ten or more clients per week) FSWs/MSM are more vulnerable and require prioritization. However, regular outreach is important for FSWs/MSM with medium volume (5-9 clients per week) and low volume (4 or less clients per week).
- Outreach components should be tailored to the specific **types of sex** typically performed.
- **Typology of sex work** is important as each typology has different characteristics, and outreach needs to be designed accordingly. The provision of outreach to urban FSWs/MSM who solicit on streets requires a strong peer network. A venue-based site, like a bar, brothel, or lodge-based site, will need strong advocacy with the bar managers and other power structures.
- **Age** is an important consideration for outreach programme design because younger FSWs/

MSM have different concerns and needs than those who are older. For example, those who are younger may be concerned with family planning, maintaining their physical appearance, and maximizing their client load. Older FSWs may be more concerned with finding economic alternatives and protecting their children.

- Experience of violence and consumption of alcohol or drugs increases sex workers' **vulnerability** to HIV and STI. Therefore, profiling sex workers' vulnerability and prioritising those who are more vulnerable are important.

#### **Risk Varies with Typology**

It is important to note that typologies of female sex workers who have higher client volume are at greater risk of HIV transmission. As programmes develop outreach strategies, priority should be given to typologies that are at greater risk because of higher client volumes.

New entrants into these typologies also warrant special attention from outreach workers because new entrants are often younger and less likely to have been exposed to HIV-related information or services.

### **2.5.3 Engaging the Community in Micro-Planning and Implementation**

The methodology of micro-planning enables peer educators to use their knowledge of the key population to plan and prioritize outreach. On a weekly basis, peer educators document the number and type of interactions they have with community members, and they meet at least bi-weekly with supervisors to identify on-going issues, plan subsequent activities, and discuss strategies to address structural vulnerability. Peer outreach workers collect data and analyse it to plan follow-up with specific individuals in their caseload and to make sure that all individuals are being met and are receiving services.

Micro-level scale-up happens after macro-planning and development, which happen in the first year of the programme. Micro-level scale-up occurs at the level of the identified key population locations within each community.

To perform micro-planning for each identified location or hot spot, programme teams are formed that include peer educators, outreach workers, and field coordinators hired by a local non-governmental organisation (NGO). Optimal locations for outreach, drop-in centres, and clinics are identified and specific service delivery in these locations is planned. Peer educators have a unique understanding of the local situation, and providing peer educators with skills and tools to contribute to the strategic planning of outreach and services facilitates the development of relevant, practical, and acceptable services.

#### **Micro-Planning Includes Five Main Activities:**

- **Site Load Mapping:** key population-led mapping is used to systematically validate and define hot spots and their logical geographical boundaries.
- **Site Analysis:** spot profiling is performed to inform the delivery and components of HIV-prevention programmes, per key population member and per location. A simple tool collates relevant information on a particular location where FSWs/MSM/PWID are known to congregate.
- **Contact Listing / Peer Educator Social Network Analysis:** for each location, the peer educators make a list of all the FSWs/MSW/MSM/TG/PWID that they know personally, and then they compare lists. Decisions are made about which peer educator will take responsibility for outreach, education, and monitoring for each individual FSW/MSW/MSM/TG/PWID.
- **Peer Educator Planning:** A hot spot-based peer educator plan is the core micro-planning tool that is developed by a peer educator for the hot spot and the key population he or she works with. This tool helps the peer educator plan outreach at the appropriate time, day, and place.
- **Opportunity Gap Analysis:** With the opportunity gap analysis tool, peer educators compare the key population's actual service use against expected use to identify barriers that obstruct key population members' use of programme services. This exercise reveals issues that the programme must address to increase service delivery.

The information gleaned from these stages of planning is used to inform the implementation of appropriate and sufficient services to maximize coverage and achieve programme objectives. Micro-planning activities are further described in Annex 2. 2.

Micro-planning also involves identifying and engaging with existing organisations that provide services relevant to the core programme goals for HIV prevention among key populations. The specific programme and service components should be selected according to the needs and structure of the local context, and defined by the location, key population size, and characteristics. Collaboration can deliver a essential intervention package of a synergistic and complementary set of services with delivery strategies that provide broad coverage with minimal redundancies, utilizing collective pre-existing contacts and trust within the key population community.

Another objective of micro planning is to ensure that outreach is led by the community, and there are tools (listed in Table 1) that can be used to facilitate this involvement. The tools are also very community friendly and facilitate processes by which peer educators analyse information, design interventions, and monitor their work in their sites. The tools help the peer educators to become hot spot managers and help define the needs of the key populations in the site and design activities to address those needs. The involvement of the community in design, implementation, and monitoring of the outreach activities increases the appropriateness and acceptability of these programmes among the community and may result in more efficient and effective programmes based on the needs and priorities of the community.

In 2008, modes of transmission (MoT) studies and a series of research papers commissioned by *The Lancet* identified key weaknesses in HIV prevention efforts. These weaknesses included a) failure to attend to the populations at greatest risk, b) failure to focus resources on primary transmission routes and unexplained variations from year to year in resources for key prevention strategies, c) the striking deficit of structural interventions that address underlying causes of vulnerability, and d) inadequate prevention services for people

living with HIV. To address these weaknesses, HIV research and programme experts, civil society, and policy makers proposed 'combination prevention'—the evidence-informed, strategic, simultaneous use of complementary behavioural, biomedical, and structural prevention strategies.<sup>72</sup>

## 2.6

### COMBINATION PREVENTION PACKAGE FOR KEY POPULATIONS

Effective prevention strategies are distinguished by using a combination of behavioural, structural, and biomedical interventions in coordination. Combination prevention programmes operate on individual, family, community, and societal levels to address the specific needs of the populations at risk of HIV infection. Combination prevention takes a bottom-up approach that encourages ownership of the response by local communities. The HIV-prevention programme for key populations is based on a combination prevention approach that addresses behavioural, biomedical, and structural components.

To ensure that key populations across the country receive the essential services to minimise risk and vulnerability to HIV and STI infections, an essential service package has been developed for programmes in Kenya. The essential package contains the vital services, activities, facilities, and information that all HIV programmes with key populations should provide. The efficacy of the components of the essential package is strongly supported by evidence. However, new research and new international guidelines show that there are other interventions that are showing promising results for key populations. These interventions are recommended as desirable elements, though they are not considered necessary for preventing the spread of HIV. If organisations have resources and expertise, they can add desirable interventions in their programme.

Given current evidence on the combined efficacy

72 UNAIDS. 2010. *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections*. A UNAIDS Discussion Paper. Geneva: UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2007\\_Combination\\_Prevention\\_paper\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2007_Combination_Prevention_paper_en.pdf)

of condom use, peer education, outreach, STI screening and treatment, HIV testing and counselling, needle and syringe programming, and the creation of an enabling environment, any implementation programme working with key populations in Kenya should design their budgets to provide all of these basic services.

### 2.6.1 Essential Combination Prevention Package and Desirable Elements

#### Essential Package

- Peer education
- Targeted information, education, and communication
- Promotion, demonstration, and distribution of male and female condoms and water-based lubricants, needles, and syringes
- Risk assessment, risk-reduction counselling, and skills-building
- Evidence-informed behavioural interventions
- Comprehensive condoms and lubricant programming
- Harm reduction for people who inject drugs
- ARV-related prevention
- HIV testing and counselling
- STI prevention, screening, and treatment
- HIV care and treatment
- TB screening and referral to treatment
- Shaping policy and creating enabling environments
- Reducing stigma and discrimination
- Empowering the community, including ownership and leadership
- Violence prevention and response

#### Desirable Elements

- Viral hepatitis screening, vaccination, treatment and care
- Mental health
- Family planning
- Post-abortion care
- Cervical cancer screening and treatment
- Screening for anal and other cancers
- Emergency contraception

Drawing on the nine interventions in the WHO *Technical Guide*,<sup>73</sup> NASCOP advises including the following 10 interventions in a comprehensive essential package, to which all people who inject drugs should have access:

1. Community-based outreach\*
2. Targeted IEC materials and campaigns for PWID and their sexual partners
3. Condoms programmes targeted specifically at PWID and their sexual partners
4. Needle & syringe programmes
5. Medication-assisted treatment and other drug-dependence treatment
6. HIV counselling and testing
7. Antiretroviral therapy (for PWID who are living with HIV)
8. Prevention and treatment of STI
9. Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
10. Prevention, diagnosis, and treatment of tuberculosis.

\*The WHO *Technical Guide* recognizes community-based outreach as a service delivery method, not as a stand-alone intervention.

#### Important Points in Programme Implementation/Service Provision

Implementers, development partners, and government technical support agencies need to consider the local context.

Despite the need to maintain consistency in the package of interventions, the activities of implementing agencies may differ depending on the availability of ancillary services in the programme, and in the private and public sectors.

<sup>73</sup> WHO, UNODC, UNAIDS. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users – 2012 Revision*. Geneva: WHO. [http://www.who.int/hiv/pub/idu/targets\\_universal\\_access/en/](http://www.who.int/hiv/pub/idu/targets_universal_access/en/)

The delivery of biomedical interventions, such as STI management; HIV testing and counselling; and HIV treatment, care, and support, can often be provided through referrals and linkages with local public- and private-sector providers, with the national guidelines setting the benchmarks.

Given the varied geographic and cultural settings in which key populations live and work, implementers need to work closely with these populations to define priorities for structural interventions to reduce vulnerability.

## 2.7

### BEHAVIOURAL INTERVENTIONS

Behavioural interventions include a range of communication programmes to change sexual behaviour. These programmes use various communication channels (e.g., mass media, community-level, and interpersonal) to disseminate messages designed to encourage people to reduce behaviours that increase risk of HIV and increase behaviours that are protective (e.g., benefits of using a condom correctly and consistently, benefits of using new or sterile needles). Behavioural interventions also are aimed to increase the acceptability and demand for biomedical interventions.<sup>74</sup>

To reduce their risk of acquiring STIs or HIV, people must understand their risk and have the knowledge, skills, and confidence in their self-efficacy to reduce that risk. Behavioural interventions provide information, motivation, education, and skills-building to help individuals reduce risky behaviours and sustain this positive change. Behavioural interventions may address individuals or groups. One-on-one counselling may focus on awareness of personal risk and risk reduction strategies; for example, counsellors or community workers may discuss risk behaviours, relate a participant's activities directly to HIV risk, and consider strategies to reduce this risk. In contrast, peer-to-peer interventions and group sessions may focus more on awareness of risk

overall, with group sessions offering the added benefit of group support for finding workable risk-reduction strategies. Social marketing campaigns also may help by promoting testing, treatment, and other services.

Behavioural change interventions can be delivered as part of the other interventions in the comprehensive package. They may take place face-to-face or through broadcast mass media and digital media such as the Internet. Choices of content and approach, as well as of the medium, should be based on good formative analysis of the local situation. Although the logic of behavioural interventions is primarily based on individual awareness and decision-making about risk, such interventions can operate also at the community level. For example, interventions may involve training opinion leaders to communicate with their peers, thus changing perceptions of social norms about risk and risk avoidance.

There is evidence that different strategies work with different key populations. The following strategies are recommended to increase safer sexual behaviours and increase uptake of HIV testing and counselling among men who have sex with men:

- targeted Internet-based information
- social marketing strategies
- sex-venue-based outreach

Implementing both individual-level behavioural interventions and community-level behavioural interventions is suggested.<sup>75</sup>

Behavioural interventions for PWID should address risk related to both drug use and sexual behaviour.<sup>76</sup> PWID and the relevant community networks should participate in developing and delivering messages. Peer interventions are especially effective, and information and education about safe injecting and overdose prevention are also very important.

74 PEPFAR (The U.S. President's Emergency Plan for AIDS Relief). 2011. *Guidance for the Prevention of Sexually Transmitted HIV Infections*. <http://www.pepfar.gov/documents/organization/171303.pdf>.

75 WHO. 2011. *Guidelines: Prevention and Treatment of HIV and Other Sexually Transmitted Infections among Men Who Have Sex with Men and Transgender People: Recommendations for a Public Health Approach*. Geneva: WHO. [http://www.who.int/iris/bitstream/10665/44619/1/9789241501750\\_eng.pdf](http://www.who.int/iris/bitstream/10665/44619/1/9789241501750_eng.pdf)

76 WHO. 2007. *Guide to Starting and Managing Needle and Syringe Programmes*. Geneva: WHO. [http://whqlibdoc.who.int/publications/2007/9789241596275\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241596275_eng.pdf)

Among sex workers, condom promotion programmes, including community-led programmes, can increase condom use. Through peer- and community-led interventions, these programmes provide information and skills-building for condom use and create demand for HIV testing, STI screening, and HIV treatment and care.<sup>77</sup>

Behavioural interventions should contribute to an increased number of protected sexual acts, encourage adherence to biomedical components that prevent HIV transmission, and enhance individual- and group-level ownership and sustainability of programmes. More information about behaviour change communication is provided in Annex 2.6.

#### Essential Behavioural Interventions

- Peer education
- Targeted information, education, and communication (IEC) for KP
- Promotion, demonstration, and distribution of male and female condoms and water-based lubricants, needles, and syringes
- Risk assessment, risk-reduction counselling, and skills-building
- Evidence-informed behavioural interventions (EBI)

### 2.7.1 Peer Education

Peer education is an arrangement by which individuals teach their peers. A systematic review and meta-analysis of HIV-prevention interventions found peer education to be significantly associated with increased levels of knowledge about HIV, reduced STI prevalence, and increased condom use with casual and regular sex partners.<sup>78</sup>

A peer educator is a person from the key population who works with her/his colleagues to influence attitude and behaviour change. He/she shares many of the same characteristics and life experiences of his/her respective population and should be selected to represent the key population typologies and contexts present within the programme catchment area. He/She lives the

life of the people being served. It is important to note that MSM/MSW cannot be peer educators for female sex workers and vice versa.

Peer educators are responsible for providing information on HIV/STIs and harm reduction, and promoting condom use among colleagues/peers. They also distribute condoms, lubricants, needles and syringes. Peer educators carefully maintain records of their outreach. They use these records to assess and plan their work, and share these records with the implementing organisation, which uses the data for monitoring the programme.

In recent years, the role of peer educators has expanded to support their key population members in the time of crisis, inform them about their rights and entitlements, and mobilise them for collective action.

Peer educators are familiar with the challenges and stigma experienced by key populations. This facilitates credibility and trust within the community as well as a sense that peer educators are sympathetic to difficulties experienced by community members. As role models, peer educators can challenge social norms, and as a link between communities and the programme, they facilitate local participation in programmes.

#### Role of the Peer Educator

The role of the peer educator within a programme varies depending on the programmes context and vision. Peer educators are expected to perform the majority of the outreach, with the outreach workers providing managerial/technical support where needed. A strong supportive structure of full-time outreach staff is required to sustain continuity and provide on-going support to peer educators. The ideal peer educator is able to reach his/her contact at least once in 15 days.

Peer educators' roles and responsibilities are divided into essential and desirable components:

#### Essential responsibilities

1. Contact
  - a. New key population members
  - b. Key population members already enrolled/registered within the programme

<sup>77</sup> WHO. 2013. *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*. Geneva: WHO. [http://www.who.int/hiv/pub/sti/sex\\_worker\\_implementation](http://www.who.int/hiv/pub/sti/sex_worker_implementation)

<sup>78</sup> NASCOP. 2010. *National Guidelines for HIV/STI Programs for Sex Workers*. Nairobi: NASCOP. <http://nascop.or.ke/library/Marps/Sex%20Worker%20Guidelines.pdf>

2. Conduct individual risk assessment, risk reduction, skills building for risk reduction
3. Generate demand for services—encourage and motivate peers to know their HIV status
4. Distribute and demonstrate use of risk-reduction commodities
  - a. Condoms
  - b. Condom compatible lube, needle syringes and related equipment
5. Provide correct HIV/STI and reproductive health information
6. Provide dialogue-based interpersonal communication (IPC) materials on HIV risk
  - a. Condom and lubricant demonstration and distribution
  - b. Negotiating with drunk clients
  - c. Healthcare services
7. Assess the needs of peers and if necessary refer for HIV/STI/TB/PEP/violence prevention and redress
8. Advocate for rights and safety with known power structures: police, brothel owners, etc.
9. Monitor service provision
  - a. Attend review meetings
  - b. Prepare and present daily reports to outreach workers

### Desirable responsibilities

1. Crisis management
2. Peer counselling

### Peer Education Implementation

The coverage and effectiveness of service delivery depend on the quality of the peer-education and outreach programmes. To ensure that quality is maintained, NASCOP with partners developed a set of 12 standards for peer education to ensure that coverage and service delivery quality across programmes are maintained. These standards are listed in the resources at the end of this section.

Since outreach is the basis of service provision and since peers are the cornerstone of outreach, identifying the *right* peer educators is critical.

The right peer educator is representative of his/her community in terms of

- Age (18-25, 26-35, 36-49, 50 and above)
- Sex (Female, male, and transgender)

- Typology (FSW, MSW, MSM, TG, PWID)
- Site (location of work)
- Personal social network (Wide social network of peer group members)

### Selection Criteria for a Peer Educator

To qualify as a peer educator, a key population member should have the following:

1. Social Agency
  - a. Be a recognized member and/or leader in the community
  - b. Be accepted by his/her community
  - c. Be a role model for his/her community
  - d. Have regular contact with his/her group of peers as per the suggested peer ratio
  - e. Be knowledgeable about the local context and setting and current issues
2. Personal Qualities
  - a. Practice low-risk behaviour
  - b. Be prepared to commit a certain amount of time to peer education activities
  - c. Be available and willing to volunteer
  - d. Be interested in his/her work
  - e. Be committed to the goals and objectives of the programme
  - f. Be polite and show patience
  - g. Be a good mobilizer
  - h. Have good listening, communication, and inter-personal skills
  - i. Be concerned about the well-being of his/her peers
  - j. Be honest, trustworthy, and discreet (know how to keep secrets)
  - k. Be tolerant, non-judgmental, and respectful of others' ideas and behaviours
3. Organisational aptitude
  - a. Be fluent in the appropriate language
  - b. Be able to organise and conduct educational sessions
  - c. Be willing to learn and experiment in the field

### Capacity Building for Peer Educators

A training programme using the NASCOP curriculum for peer educators is crucial for success. Training can include small and large group discussions, brainstorming sessions, role play, lectures and demonstrations, storytelling and experience sharing, and field visits.

The aim of the training programme is to provide participants with knowledge and skills related to the following areas:

- Sex and sexuality
- Sexual and reproductive health
- STI and peer role in STI management
- Basics of HIV/AIDS
- Condom/risk-reduction commodity promotion
- The impact of alcohol and substance abuse on risk, and mitigation strategies
- Self-esteem
- Legal situation and rights
- Care for people living with HIV
- Community mobilisation
- Peer-led monitoring
- Advocacy

Peer educators also require capacity strengthening in basic micro-planning for programme scale-up, accountability to the programme and community, literacy and leadership building (e.g., a clear career path), facilitation skills for interpersonal communication sessions, and committee and institution building beyond HIV issues.

Initially, considerable management resources should be devoted to overseeing the development of the training programme, including the use of a training guide, the training of trainers, and the successful initiation of the programme's first peer educators in each sub-county. Over time, senior peer educators can be provided with additional training and promoted to full-time outreach workers.

### Review and Growth/Development of Peer Educators in the Programme

Every six months, the performance of peer educators should be reviewed against programme coverage indicators (shown in Figure 7). The

ultimate goal is for 100% coverage of the identified gaps, so from a funnel the programme coverage schematic appears as a cylinder. The review should be conducted using the Opportunity Gap Analysis tool (described in Annex 2.2.4), which encourages self-reflection and self-review. This will ensure that the peer educators assume greater responsibility and accountability for their performance rather than being policed and monitored by the programme team.

The programmes may also organise reflection forums every six months with the local key population so that peer educators can get direct feedback on their performance. This will reinforce the fact that peer educators are accountable to the local key population rather than just the programme.

- For FSWs, the ideal peer educator to KP member ratio, as derived from program experience and community consultations, is set at a range of between 1:60–80 (1 PE for 60–80 FSWs).
- For MSM and MSWs, the recommended ratio range is between 1:30–40.
- For PWID, the recommended ratio is 1:40.

A peer educator is given incentives/remuneration as per the national programme guidelines, as specified in Chapter 3.

### Challenges Peer Educators May Encounter

1. Lack of knowledge and skills needed to inform peers
2. Peer education requires extra time and commitment
3. Loss of motivation
4. Peers may be jealous
5. Being a role model needs behaviour change yet some may continue to practice risky behaviour
6. Breach of confidentiality

### 2.7.2 Targeted Information, Education, and Communication for Key Populations

Communicating with key populations for promoting health-seeking behavior, safer sex, uptake of counselling and testing for HIV, and other aspects related to the prevention, care, and treatment of HIV is a constant challenge. The National AIDs and STI Control Programme Technical Support Unit has adapted concepts and materials from other programmes to address these challenges and has developed and effectively used communication tools and materials that have proven effective. Additionally, there is a common component of communication hooks, such as money, beauty, health, welfare of their children, and relationship with their regular partners, which are used to attract key population members, build rapport, sustain their interest, and initiate dialogue with them regarding risk behaviors and desired behavior change. The IPC materials are being used to help the KPs achieve stability and happiness in relation to their priority areas and thus encourage healthy living, and to increase uptake of clinical services and condom utilisation.

### 2.7.3 Promotion, demonstration, and distribution of male and female condoms and water-based lubricants, needles, and syringes

Although distribution of male and female condoms, water-based lubricants, needles, and syringes is an essential biomedical intervention for halting HIV and STI transmission, the effectiveness of such products depends upon behavioural interventions that spread demand for such products and that increase their correct and consistent use. Behavioural interventions to promote protective products should occur at three levels:<sup>79</sup>

- Individual-level intervention through which peer educators explain the importance of correct and consistent use of such products, demonstrate their use, and train key populations to persuade their partners to use such products

- Community-level intervention to promote behavioural and attitudinal norms about safe sex and safe injecting practices
- Institutional-level intervention through which service providers reinforce behaviour-change messages about the importance of using condoms, lubricant, and clean injecting equipment

### 2.7.4 Risk Assessment, Risk-Reduction Counselling, and Skills-Building

Counselling and skills-building provide key populations with information and skills for HIV-risk reduction. When conducting risk assessment, questions should focus on frequency of oral, anal, and vaginal sex; number of clients and regular partners; condom use with clients and regular sex partners; lubricant use; douching; dry sex; and substance use. The counsellor should be able to counsel in a non-judgmental way and avoid stigmatisation and embarrassment. Counselling can be provided in the clinics and drop-in centres. Counselling should be done in a safe and private space, and confidentiality must be maintained. Counsellors should provide options to key populations and encourage them to solve their problems.

#### **Risk-reduction plans should have behavioural goals and should follow the following steps:**

- Conduct an initial and on-going individual HIV/STI risk assessment.
- Develop a personalized risk reduction plan in collaboration with the sex worker.
- Routinely monitor progress of risk reduction and modify/adjust the plan as necessary.
- Provide risk reduction supplies (i.e., male/female condoms and latex-compatible lubricant).
- Build the key population's skills to reduce their risks.
- Routinely reinforce their risk reduction skills.
- Assess other needs of the FSW/MSM/MSW/TG/PWID and link them to other programmes that address those needs.

<sup>79</sup> Pathfinder International. 2014. *Combination Prevention of HIV: A Technical Guide to Working with Key Affected Populations*. Watertown, MA: Pathfinder International. [http://www.pathfinder.org/publications-tools/pdfs/Combination-HIV-Prevention-Technical-Guide-to-Working-with-KAPs\\_FINAL\\_25Feb14.pdf](http://www.pathfinder.org/publications-tools/pdfs/Combination-HIV-Prevention-Technical-Guide-to-Working-with-KAPs_FINAL_25Feb14.pdf)

- For PWID outreach workers should conduct a brief intervention on the prevention of substance use which covers
  - ▶ risk associated with sharing drug-injecting paraphernalia
  - ▶ risk associated with duration of use
  - ▶ risk associated with substance use

### 2.7.5 Evidence-Informed Behavioural Intervention

When possible, the essential behavioural interventions should be achieved through a standardized evidence-informed behavioural intervention (EBI) endorsed by NASCOP's EBI Technical Working Group. The EBI TWG has packaged several EBIs appropriate for key populations including RESPECT-K and Sister to Sister.

The purpose of Sister to Sister is to provide intensive, culturally sensitive health information to empower and educate women in a clinical setting; help women understand the various behaviours that put them at risk for HIV and other STDs; and enhance women's knowledge, beliefs, motivation, confidence, and skills to help them make behavioural changes that will reduce their risk for STDs, especially HIV. Sister to Sister integrates and uses videos to build self-efficacy to motivate the women to want to be safe sexually.

RESPECT-K is another EBI targeting key populations at risk of acquiring or transmitting HIV. The intervention complements the HTC service, enhances key population members' risk perception, and supports the development of individualized risk-reduction plans.

If an appropriate packaged EBI does not exist for a specific key population, providers can use another or develop a behavioural intervention, and the *Kenya HIV Prevention Intervention Assessment Tool* (KHPIAT) can be used to systematically assess the HIV-prevention behavioral intervention to determine if it includes characteristics found in effective programmes and covers conventional health education standards.<sup>80</sup>

## 2.8

### BIOMEDICAL INTERVENTIONS

Biomedical interventions are those that directly influence the biological systems through which the virus infects a new host, so as to block virus transmission (e.g., male and female condoms), decrease infectiousness (e.g., antiretroviral therapy [ART] in prevention), or reduce risk of acquiring infection (e.g., voluntary medical male circumcision, STI management).<sup>81</sup>

Specifically, these interventions involve clinical testing, diagnosis of infections and their treatment, and other clinical services that improve the health of key populations. Biomedical interventions include STI screening and treatment; HIV testing and counselling; tuberculosis (TB) screening and referral linkages; HIV-related treatment (for opportunistic infections) and care; promotion, demonstration, and distribution of male and female condoms and latex-compatible lubricants; family planning; sexual and reproductive health services; post-abortion care services; cervical cancer screening; emergency contraception; post-rape care & post-exposure prophylaxis (PEP); screening and management of Hepatitis B; needle and syringe programme; medically assisted therapy. These interventions should be provided through community outreach, community-friendly clinic programmes, and referral cycles, with the involvement of peer educators, project outreach staff, counsellors, doctors, and community self-help groups.

#### Essential Biomedical Interventions

- Comprehensive condoms and lubricant programming
- Harm reduction for people who inject drugs (Needle and Syringe Programme and Opioid Substitution Therapy)
- ARV-related prevention
- HIV testing and counselling
- STI prevention, screening, and treatment (oral and anal STI services for MSM, MSW, and TG)
- HIV care and treatment (ART and EMTCT)
- TB screening and referral to treatment

<sup>80</sup> NASCOP. 2012 *Kenya HIV Prevention Intervention Assessment Tool*. Nairobi: NASCOP. <http://nascop.or.ke/library/khpiat/Kenya%20HIV%20Prevention%20Intervention.pdf>

<sup>81</sup> PEPFAR (The U.S. President's Emergency Plan for AIDS Relief). 2011. *Guidance for the Prevention of Sexually Transmitted HIV Infections*. <http://www.pepfar.gov/documents/organization/171303.pdf>.

**Desirable Biomedical Interventions**

- Viral hepatitis screening, vaccination, treatment and care
- Mental health
- Family planning
- Post-abortion care
- Cervical cancer screening and treatment
- Screening for anal and other cancers
- Emergency contraception

**Essential Biomedical Interventions****2.8.1 Comprehensive Condom and Lubricant Programming**

The goal of comprehensive condom and lubricant programming is to increase the availability, accessibility, affordability, and use of male and female condoms and condom-compatible lubricants among people from key populations. Male condoms, when used correctly and consistently, reduce sexual transmission of HIV and other STIs in both vaginal and anal sex by up to 94%. Use of water-based or silicone-based lubricants helps to prevent condoms from breaking and slipping.<sup>82</sup>

UNFPA defines condom programming for HIV prevention as a means of ensuring that those sexually active persons at risk of HIV are motivated to use condoms, have access to quality condoms, and can use them consistently and correctly. A comprehensive condom programme, therefore, addresses demand, supply, and support for male and female condoms as a means of protection from STIs/HIV and unintended pregnancy. It entails putting into place a constellation of inter-related elements, including, assessing and meeting user needs; overcoming barriers to access and use; promoting; forecasting needs; facilitating procurement according to internally accepted standards and specifications; logistics management, including transport and storage; expanding channels for distribution; and monitoring impact.

There are four key components of strengthening condom programming: 1) high quality, affordable condoms; 2) increasing demand for condoms

among key populations; 3) increasing demand for safer sex behaviours in persons with high-risk behaviours in the general population; and 4) enhancing an enabling environment for condom use.

Comprehensive condom programming integrates various activities, including male and female condom promotion, communication for behaviour change, market research, segmentation of messages, optimized use of entry points (in both reproductive health clinics and HIV prevention venues), advocacy, and coordinated management of supplies.

Strategic condom programming recognizes the complementarity between male and female condoms. For anal sex, latex condoms and lubricants must be provided together, ideally in one package.

**Highlights from the UNAIDS Position Statement on Condoms and HIV Prevention**

- Condom use is a critical element in a comprehensive, effective, and sustainable approach to HIV prevention and treatment.
- The male latex condom is the single most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections.
- Condoms must be readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use.
- HIV-prevention education and condom promotion must overcome the challenges of complex gender and cultural factors.
- Condoms have played a decisive role in HIV-prevention efforts in many countries.
- Increased access to antiretroviral treatment creates the need and the opportunity for accelerated condom promotion.

**Gender Dimensions of Condom Use**

Physiologically, men are more likely to transmit HIV to women than vice versa. Although condoms can provide effective protection against HIV

<sup>82</sup> UNFPA, WHO, UNAIDS. 2009. Position statement on condoms and HIV prevention. [http://data.unaids.org/pub/BaseDocument/2009/20090318\\_position\\_paper\\_condoms\\_en.pdf](http://data.unaids.org/pub/BaseDocument/2009/20090318_position_paper_condoms_en.pdf)

infection and female condoms are agreed to increase women's empowerment, several factors affect peoples' decision making about the use of both male and female condoms. Cost, availability, and perceptions of risk are important factors. Power relations between men and women, including the relative social and economic status of partners, influence the extent to which condom use can be successfully negotiated.

Accepted notions of masculinity and femininity also come into play. For instance, in many cultural settings, young women are supposed to be sexually innocent and may therefore be reluctant to carry or suggest using condoms. Since condoms are also associated in many contexts with illicit or extra-marital sex, married women are often powerless to request their partner to wear a condom despite suspecting that he may be infected with HIV, for fear of reprisal at the implied accusation of infidelity.

### Demonstration, Promotion, and Distribution of Condoms and Lubricants

**The objectives** of condom demonstration, promotion, and distribution with latex-compatible lubricant are

- to make condoms and lubricants and other commodities available and accessible,
- to distribute an adequate number of free condoms and lubricants and other commodities to meet the individual needs of FSW/MSM/MSW/TG,
- to encourage the correct and consistent use of condoms and lubricants and build condom negotiation skills, and
- to promote the use of condoms and lubricants and other commodities.

**Address barriers to condom usage** – It is important to understand factors affecting condom usage among key populations at the implementation site before initiating condom programming.

- The barriers to condom usage (e.g., alcohol intake, 'difficult clients')

- Misconceptions and myths regarding condom usage (e.g., not required for anal sex)
- Condom availability in the area
- Condom storage at the consumer level
- Condom accessibility. Are condoms available at the point of sex (or does FSW/MSM/MSW/TG have to travel to procure the condom) and at the time of sex (often in the evening/at night)?

### Free Condom Procurement/Reporting

- Each implementing partner should ensure they have an adequate stock of condoms. Re-ordering is recommended when there is three-months stock on hand.
- Implementing partners should have adequate storage space for condoms. Care should be taken that they do not become damaged in storage or during transit to outlets.
- Condom supplies should be documented. Implementing partners should maintain data on where, when, and how many condoms are supplied.
- When assessing condom requirements, those required for demonstrations and trainings should be factored in.
- Condom programming should be assessed as part of the annual review/evaluation and appropriate redesigning done accordingly.

### Assessing Condom Requirements

Assessing the condom requirement at each site of intervention is critical in order to ensure condoms are not being 'dumped' or stock-outs are not occurring. Condom demand depends on the risk profile of each individual site.

**The following formula can be used to calculate condom requirement for a sex worker:**

$$D = (I \times N)$$

- **D** is the condom requirement (demand)
- **I** is the number of sex acts per day
- **N** is the number of days that the sex worker works in a given month
- **I and N** can be determined through the processes of site assessment, outreach, and peer plans.

For example, if a peer educator's records show that a sex worker has an average of three clients per day and works 16 days in a month, the peer educator knows that that sex worker needs not less than 48 condoms per month.

To calculate a site's monthly condom requirement, the requirements of all sex workers at the site are summed.

### Condom Distribution Channels

**Direct distribution** – Condoms directly given to key population members are less likely to be wasted and are more likely to be used.

- Distribution by PEs and ORWs to key population members in the field
- At the DIC
- At the STI clinic

**Indirect distribution** – Locations should be chosen carefully to minimise wastage and the chance of the condoms being sold.

- Condom outlets (e.g., public toilets, petty shops, lodges)
- Condom stockists from the sex circuit (e.g., lodges, bars, brothel madams, brokers)

Condom promotion must be done without any coercion. Building condom negotiating skills with clients and regular partners is an important aspect of outreach. Advocacy with law enforcement agencies is important to ensure that possession of condoms is not used as evidence of sex-related criminal activity.

### Implementation Considerations

Programmes should monitor condom and lube distribution, availability, accessibility, and usage:

- There should be support for condom programming from all departments, especially from law enforcement. Possession of condoms should not be used as evidence of criminal activity, and police/askaris should not harass peer educators and outreach workers who carry condoms and lubes.
- Promoting access is important and hence condoms and lube should be free so that any barrier related to cost is removed. Condoms and lubes should be available through multiple outlets in enough numbers and any time. Peer educators need to do condom and lube planning using peer plans. Indent for

condoms and lubes must be given in advance to avoid stock-out situation. Condom promotion campaigns should be undertaken to increase awareness and promote acceptability and benefits of condoms (disease and pregnancy prevention).

- Along with promotion and supply, programmes for key populations should also offer information and skills building in negotiating condom use for key populations. Skill building sessions should acknowledge power and gender imbalance in condom use settings and address the same. Condom demonstration and re-demonstration should be done as part of routine practice. Studies have shown that condom burst and slippage experience is linked to incorrect use of the condom.

**Monitoring usage** – Key population condom use behaviour should be measured at baseline and subsequently monitored to assess behaviour change and programme impact.

The identification and formulation of effective HIV control strategies require reliable and accurate data about dynamics of HIV transmission and STI infections. But reliable and accurate data about sexual behaviour are often difficult to obtain. For both behavioural outcome assessment and to aid the revision of behaviour change communication strategies, rigorous, evidence-based empirical assessment of condom usage and other service utilisation by target group members influenced by the interventions is indispensable. Transmission and acquisition of HIV/STIs are primarily through high-risk behaviours, involving sexual contact considered highly personal and sensitive. Self-reporting of sexual behaviour is heavily influenced by personal and contextual barriers, such as predisposition to self-disclosure, poor recall, perceptions of confidentiality, and social desirability bias. Hence, survey methods that offer a greater level of privacy for respondents and assure anonymity of their response are more likely to elicit comparatively accurate data. It is in this context that data collection methods such as polling booth surveys gain value over methods of self-administered questionnaire and face-to-face interview.

**A polling booth survey** is a group interview method whereby participants give their responses through a ballot box. In this method, the individual responses are anonymous and unlinked (i.e., an individual respondent is not linked to the response). This anonymity assures respondents of confidentiality, encouraging them to accurately disclose sensitive personal information. It is recommended that polling booth surveys be incorporated into implementing partner programme design to understand condom usage and barriers.

### Social Marketing of Condoms

Social marketing may be defined as the adaptation of commercial marketing and sales concepts and techniques to the attainment of social goals. It seeks to make health-related information, products, and services easily available and affordable to low-income populations and those at risk while at the same time promoting the adoption of healthier behaviour. In fact, it may be said that the ultimate goal of social marketing is to effect healthy and sustainable behaviour change.<sup>83</sup>

**Condom social marketing for key populations** should take a two-pronged approach:

**1. Implementing partners, through NGOs and community-led organisations, enable availability of socially marketed condoms at hot spots.**

Social marketing aims to make sure that different brands of condoms (preferred choices) are available at/near pickup points / places of sex (hot spots), including bars and lodges where sex work happens. Implementing partners should prioritise all hot spots in towns with over 50 key population members. Implementing partners should collaborate with NASCOP (CASCOs/ County-level-equivalent/ TSU field officers) within their project area to ensure that condoms are being stocked at hot spots. Implementing partners can ensure the availability of condoms at hot spots by

- **identifying locations/areas** where access to condoms should be assured and officially conveying the information

to [relevant] NASCOP agencies

- **providing feedback** to [relevant] NASCOP agencies on a regular basis regarding availability of condoms and incidents of stock-outs in the intervention area
- **sharing information** with [relevant] NASCOP agencies on newly identified high-risk locations and hot spots as and when identified
- **creating awareness** of the availability of condoms among key and bridge populations
- **meeting periodically** with [relevant] NASCOP agencies to share the field realities and for further improvement.

**2. Community-led organisations sell socially marketed condoms to key populations.**

In select cases where established demand from the community requires it, NGOs and/or community-led organisations may choose to provide socially marketed condoms to key populations. The rationale behind the selective sale of condoms is, 'A condom bought is a condom used.' It is therefore anticipated that 70%–90% of condoms for key populations will be available for free, and only in select locations (around 10% of key populations) will condoms be socially marketed.

### 2.8.2 Harm Reduction for People Who Inject Drugs

A comprehensive package of evidence based intervention to reduce harms associated with injecting drug use has been developed and endorsed by United Nations, Global fund and PEPFAR. The comprehensive harm reduction package include:

1. Needle and syringe programme (NSP)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of STIs

<sup>83</sup> UNAIDS. 2000. Condom Social Marketing: Selected Case Studies. Geneva: UNAIDS. [http://data.unaids.org/publications/IRC-pub02/jc1195-condsocmark\\_en.pdf](http://data.unaids.org/publications/IRC-pub02/jc1195-condsocmark_en.pdf)

6. Condom programmes for PWID and their sexual partners
7. Targeted information, education, and communication to PWID and their sexual partners
8. Prevention, vaccination, diagnosis, and treatment for viral hepatitis
9. Prevention, diagnosis, and treatment of TB

Only the first two interventions (NSP and OST) are specific to drug use and discussed in this chapter.

### Needle and Syringe Programmes

Once HIV is introduced in a population of people who inject drugs and commonly share syringes and injecting equipment, prevalence rates can reach epidemic proportions very quickly.<sup>84</sup> Distributing free or low-cost sterile injecting equipment to people who inject facilitates the use of clean needles and syringes and reduces the number of injections with used needles and syringes.<sup>85</sup>

NSPs may serve as an important point of entry to other services. NSPs aim to engage their PWID clients repeatedly on a regular basis. Thus, they have multiple opportunities to facilitate access to other health services such as OST and other drug dependence treatment, HTC, and treatment of HIV, TB and viral hepatitis.<sup>86</sup> Also, NSPs may offer basic health care and address other specific issues that commonly affect people who inject drugs, such as wound care and overdose prevention. Various models of needle and syringe distribution and service delivery can be employed, including distribution at fixed sites, mobile and outreach services, through drop in centres. To prevent HIV transmission through injecting drug use, it is crucial to provide not only information on how to do so, through safer injecting and avoiding sharing injecting equipment, but also the means to do so, through distribution of free or low-cost sterile injecting equipment.

### Implementation Considerations

- Programmes should promote a supportive policy, legal, and social environment that facilitates equitable access to HIV prevention and treatment for all, including NSPs, for people who inject drugs.
- Advocacy citing public health evidence is often required with various sectors, especially law enforcement agencies and the local community, to foster an environment that enables NSPs to function fully.
- It is important that NSPs are sensitized to the health needs of each key population. Key population organizations should provide these interventions themselves or have effective referral pathways to services that do. In addition to needles and syringes, other injecting-related equipment may also be provided, including alcohol swabs, ampoules of sterile water, filters, tourniquets, mixing vessels (e.g., spoons or 'cookers') and acidifiers (e.g., ascorbic acid or citric acid powders)
- NSPs should set up systems for safe disposal of injecting equipment and promote their use. There are various models for safe disposal systems, including distributing puncture-resistant one-way containers. Effective safe disposal reduces the amount of contaminated equipment in the community, thus reducing reuse and unintended needle-sticks and limiting negative reactions from the community. Information provided also can cover opportunities for reducing drug use in the longer term.
- Women who inject drugs face additional risk and barriers to services. NSPs should ensure that special attention is given to understand the needs and barriers of women who inject drugs and design the intervention address these specific needs and barriers.

### Opioid Substitution Therapy

Interventions that effectively treat drug dependence can reduce illicit drug use and, hence, the frequency of injection, as well as improve health and social functioning. For people dependent on opioids, agonist opioid substitution

84 Ball A, 1998. Policies and interventions to stem HIV-1 epidemics associated with injecting drug use. In Stimson GV, Des Jarlais DC, Ball A, eds. *Drug Injecting and HIV Infection*. London: UCL Press.

85 WHO, UNODC, UNAIDS. 2012. Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users – 2012 revision. Geneva: WHO. [http://www.who.int/hiv/pub/idu/targets\\_universal\\_access/en/](http://www.who.int/hiv/pub/idu/targets_universal_access/en/)

86 WHO. 2004. Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission. Geneva: WHO. [http://whqlibdoc.who.int/hq/2004/WHO\\_HIV\\_2004.03.pdf?ua=1](http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.03.pdf?ua=1)

therapy—sometimes referred to as medically assisted therapy (MAT)—is highly effective in reducing injecting behaviours that put opioid-dependent people at risk for HIV.<sup>87</sup> OST can reduce opioid use and improve retention in HIV treatment.<sup>88</sup> Access and adherence to OST can improve health outcomes, reduce overdose and resulting mortality, reduce criminal activity, result in better psychosocial outcomes and decrease risk to pregnant women dependent upon drugs and to their infants. Methadone and buprenorphine, both of which are on the WHO list of essential medicines, are the most commonly used opioid agonists. Kenya uses methadone, which is a synthetic opioid used to treat heroin and other opioid dependence. It reduces opioid withdrawal symptoms and the euphoric effect when opioids are used. Methadone is taken orally on a daily basis. It is important to ensure that the dose is sufficient (60–120 mg) and is given for sufficient duration.

To achieve optimal coverage and treatment outcomes, opioid substitution therapy should be provided free of charge and should be accessible to all those in need. OST should not be compulsory; patients must give informed consent for treatment. OST should be provided as maintenance treatment for sufficient duration and at adequate doses.

### Implementation Considerations

- MAT should be provided from a centre close to the spots where PWID congregate to push drugs. If the distance to the centre providing MAT is too far, then possibility of PWID coming daily may be less.
- In the early phase of treatment, administration of methadone doses should be directly supervised.
  - Involuntary discharge from treatment is sometimes justified to ensure the safety of staff and other patients, but failure to follow programme rules alone should not generally be cause for involuntary discharge. Before involuntary discharge, reasonable measures

to improve the situation should be taken, including re-evaluation of the treatment approach.

Details on this extensive component may be comprehensively accessed within recently developed key resources by NASCOP.

## 2.8.3 ARV-Related Prevention

Antiretroviral-related (or ARV-related) prevention includes pre-exposure prophylaxis and post-exposure prophylaxis.

### Pre-Exposure Prophylaxis

Oral pre-exposure prophylaxis (PrEP) of HIV is the daily use of ARV drugs by HIV-uninfected people to block the acquisition of HIV. Studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among serodiscordant heterosexual couples, men who have sex with men, transgender women, high-risk heterosexual couples, and people who inject drugs. WHO encourages countries to undertake demonstration projects to gain experience in implementing PrEP safely and effectively.<sup>89</sup> There are few PrEP demonstration projects which have been identified in Kenya and will initiate the studies very soon. NASCOP is awaiting findings from these sites before including the same in the guidelines.

Several guidelines have recently recommended PrEP for some key populations. The U.S. Centers for Disease Control and Prevention issued guidelines in 2014 that recommended PrEP as one prevention option for sexually-active adult MSM and IDU who are at substantial risk of HIV acquisition.<sup>90</sup> Further, recently the WHO gave a strong recommendation endorsing PrEP as part of a package of prevention services for men who have sex with men.

### Post-Exposure Prophylaxis

Post-exposure prophylaxis for HIV is a 28-day course of a combination of antiretroviral drugs (ARVs) that must begin within 72 hours after

87 Institute of Medicine of the National Academies. 2007. *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: an Assessment of the Evidence*. Washington, DC: National Academy of Sciences. [http://www.nap.edu/openbook.php?record\\_id=11731](http://www.nap.edu/openbook.php?record_id=11731)

88 Ward J, Mattick RP, and Hall W, eds. 1998. *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Sydney: Harwood Academic Publishers. <http://www.drugsandalcohol.ie/3767>

89 WHO. 2012. *Guidance on Oral Pre-Exposure Prophylaxis (PrEP) for Serodiscordant Couples, Men and Transgender Women Who Have Sex with Men at High Risk of HIV: Recommendations for Use in the Context of Demonstration Projects*. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884_eng.pdf)

90 U.S. Centers for Disease Control and Prevention. 2014. *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guideline*. Atlanta, GA: CDC. <http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf>

occupational or accidental HIV exposure, such as injury from an infected needle; vaginal, oral, or anal rape; or condom break.<sup>91</sup>

According to the WHO PEP Guidelines 2007, individuals should be assessed for PEP regardless of their involvement in any activities considered to be illegal by national legislation, such as injecting drug use, sex work, or men having sex with men. Further, while PEP is not appropriate in the context of chronic exposure to HIV, high-risk single or episodic exposure (such as rape by a stranger or needle stick injury) may occur against a background of potential chronic exposure, such as regular and ongoing unprotected sex with an intimate partner. In these cases, the high-risk episodic exposure should be treated as such and PEP offered if the person is HIV-negative. The importance of reducing the on-going risk within the intimate relationship should be emphasized as part of the counselling process.

Distinguishing between chronic and episodic exposure can be difficult. Having more than one potential episode of exposure is not inherently linked with evidence of chronic exposure. For example, sex workers who would normally use a condom but have been sexually assaulted would be eligible for PEP.

The identification of repeated or chronic exposure to HIV should lead to greater emphasis on prevention. For example, in the case of sexual assault by an intimate partner with whom a person is also having on-going unprotected consensual sex, the likelihood that the on-going exposure pattern will change needs to be assessed. However, this assessment is likely to be complicated when considering individuals who are unable to prevent chronic exposure, such as women in violent intimate relationships. For others in similar chronic risk situations, a baseline risk assessment and counselling to reduce risk are critical components of a wider strategy for preventing HIV transmission and are probably more important than PEP alone.

In cases where PEP is not indicated because the exposure is chronic, other critical prevention

and care services should be provided. Effective interventions in these circumstances include referral to domestic violence organisations, providing testing and condoms, and access to needle-exchange programmes.

**Elements of PEP:** Post-exposure prophylaxis should be provided for free to key population members for suspected exposure to HIV. For key populations, PEP is recommended for accidental exposure due to a condom break, or for exposure due to vagina/anal/oral rape. When prescribing PEP service providers should

1. Establish eligibility for PEP (HIV-negative client with a suspected risk of HIV exposure in the last 72 hours from an HIV-positive person or person of unknown status).
2. Counsel key populations on benefits, limitations, and side effects of PEP.
3. Provide PEP regimen and conduct adherence counselling.
4. Retest for HIV at six weeks, three months, and six months.
5. Promote, demonstrate, and distribute condoms and lubricants.
6. Conduct risk-reduction counselling and skills building to prevent further HIV exposure.

Patients taking PEP should be forewarned about the side effects (nausea, headaches, tiredness, aches, and pains) and prepared to deal with them. They should, for instance, be informed that they can reduce the intensity by taking the pills with food. Side effects usually diminish with time and do not cause any long-term damage. The purpose of the laboratory monitoring is to pick up the more dangerous side effects, but these are extremely rare in patients taking ARVs for only one month.

**Note:** Currently, there are no parameters outlining the amount of PEP that can be offered in a year, but health care workers are encouraged to exercise caution and offer PEP only when warranted, based on risk and HIV status.

### Post-Rape Care

**Rape** is defined as an act which causes penetration of one person's genital organs with the genital (including anal rectal) organs of another without

91 Ministry of Public Health & Sanitation, Ministry of Medical Services. 2009. National Guidelines on Management of Sexual Violence in Kenya. 2nd Edition. Nairobi: Ministry of Public Health & Sanitation, Ministry of Medical Services. [http://www.endvawnow.org/uploads/browser/files/national\\_guidelines.pdf](http://www.endvawnow.org/uploads/browser/files/national_guidelines.pdf)

consent or where consent is obtained by force, threats, or intimidation of any kind.<sup>92, 93</sup>

**Sexual violence** is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's and men's sexuality using coercion, threats of harm, or physical force by any person, regardless of relationship to the victim, in any setting, including but not limited to home and work.<sup>94</sup>

Because survivors of rape and sexual violence feel uncomfortable talking about their experiences, they often come to the clinic with nonspecific complaints or requesting a check-up, assuming that the health care provider will notice anything abnormal that needs treatment. Therefore, health care workers should maintain a high index of suspicion and ask about experience of sexual violence or abuse.

While post-rape care has been briefly outlined below, comprehensive details on the management of sexual violence are available in the *National Guidelines on Management of Sexual Violence in Kenya* (2nd edition).<sup>95</sup>

### Elements of Post-Rape Care

The following services should be available onsite or through referral for key population members who have experienced sexual violence:

#### A. Visual inspection

Before examination, consent of the key-population survivor must be taken and counselling must be done. Examination of clothes, injuries, and genitals must be carried out. Look for bleeding, discharge, odour, irritation, warts, and ulcerative lesions.

#### B. Collection of forensic evidence

Forensic examination should be available to document evidence if the person chooses to take legal action. Staff should be trained in how to take forensic specimens, or referral links should be made. Forensic examination must include physical and genital examination (refer to the national guidelines).

#### C. Collection of samples for detecting STIs

If facilities permit, swabs must be collected from various sites for wet mount examination or culture of a number of causative organisms. Blood could be collected for VDRL/RPR, HIV and HbsAg tests.

#### D. Essential medical care for injuries and health problems

Medical management includes

1. Prevention of pregnancy by offering emergency contraception
2. STI prophylaxis
3. Care of injuries

**Note:** It is important to obtain informed consent for any examination, treatment, or referral in a case of a survivor of sexual assault.

#### Essential medical care for injuries and health problems would consist of

1. **Post-exposure prophylaxis** against
  - a. HIV infection
  - b. Pregnancy
2. **Psychosocial support** (both at time of crisis and long-term)  
Psychosocial management includes counselling and supportive services, which should be available onsite or by referral. Key population members who have been sexually assaulted may need shelter and legal protection.
3. **Follow-up services** for all of the above  
It is essential to explain the importance of follow-up appointments and services during the first visit. The survivor of sexual violence should be clearly told whom to contact in the event that they have further questions or subsequent physical or emotional problems related to the incident.

#### Clinical Care for Survivors of Sexual Assault

Wherever possible, clinical care for survivors of sexual assault should be linked with community-led responses to violence.

- Offer first-line support to survivors of sexual assault by any perpetrator.

<sup>92</sup> Sexual Offences Act (2006)

<sup>93</sup> Ministry of Public Health & Sanitation, Ministry of Medical Services. 2009. National Guidelines on Management of Sexual Violence in Kenya. 2nd Edition. Nairobi: Ministry of Public Health & Sanitation, Ministry of Medical Services. [http://www.endvawnow.org/uploads/browser/files/national\\_guidelines.pdf](http://www.endvawnow.org/uploads/browser/files/national_guidelines.pdf)

<sup>94</sup> Ibid.

<sup>95</sup> Ibid.

- Take a complete history to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia).
- Offer emergency contraception to women presenting within five days of sexual assault, and ideally as soon as possible after the assault to maximize effectiveness.
- Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision making with the survivor to determine whether HIV PEP is appropriate.
- Survivors of sexual assault should be offered prophylaxis for
  - ▶ chlamydia
  - ▶ gonorrhoea
  - ▶ trichomonas
  - ▶ syphilis, depending on the prevalence.
- The choice of drug and regimens should follow national guidelines.
- Hepatitis B vaccination without hepatitis B immunoglobulin should be offered as per national guidelines.
- Psychological support and care should be offered, including coping strategies for dealing with severe stress.

Interventions up to three months post-trauma

- Continue to offer support and care.
- Assess for mental health problems. If the survivor has mental health problems, provide evidence-based mental health services that are accessible, available, and follow the WHO *mhGAP Intervention Guide*.<sup>96</sup>

## 2.8.4 HIV Testing and Counselling

HIV testing and counselling (HTC) enables individuals to know their HIV status, receive counselling and support in coping with a positive or negative result and obtain HIV prevention, treatment and care services. The goal of HTC among key populations is to increase the number of those who know their HIV status and link them to HIV care and treatment services. HTC is also an important opportunity to put those at risk of HIV in contact with primary prevention programmes and encourage later retesting.

HIV testing and counselling is an integral component of HIV prevention and care strategies worldwide. HTC must always be voluntary and free from coercion. Like all testing and counselling, HTC for key populations needs to emphasize the WHO 5 Cs of HTC: consent, confidentiality, counselling, correct results and linkage to care.<sup>97</sup> It is important that there is clear and robust links between testing and HIV prevention, treatment and care services even though all the services may not be provided by one service provider. HTC services should be aligned to the current Kenya National HTC Guidelines and WHO Guidelines.

There is evidence that key populations face substantial barriers in obtaining high-quality HTC.

### For key populations, barriers include

- low risk perception
- fear of a positive test result
- distrust of free HIV testing
- inconvenient clinic operating hours
- fear that results will not be kept confidential
- fear of insensitivity, stigma, and discrimination from health care providers
- lack of convenient, 'key population-friendly' HTC services

<sup>96</sup> WHO. 2010. *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*. Geneva: WHO. [http://whqlibdoc.who.int/publications/2010/9789241548069\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf)

<sup>97</sup> WHO. 2014. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

Given the hidden nature of key populations, mobilization by their peers is critical. The aims are not only to overcome barriers to HTC but also to increase uptake of HIV care and treatment services for key populations found to be HIV-positive, and to develop the risk reduction skills of those found to be HIV-negative so they remain HIV-negative.

### Types of HTC

- **Client-Initiated HIV Testing and Counselling (CITC)** refers to a situation in which individuals, couples, or groups actively seek and undergo HIV testing and counselling at a site where these services are provided. Client-initiated HTC puts emphasis on tailored risk assessment and counselling.
- **Provider-Initiated HIV Testing and Counselling (PITC)** in health facilities is a model of HIV testing and counselling in which the healthcare provider offers and recommends HIV testing to patients as a standard component of medical care. Since post-test counselling is limited during PITC, service providers may need to refer key populations to further counselling services depending on the individual's need. Further, given the mixed HIV epidemic in Kenya, it is recommended by the WHO that all patients receiving STI screening and treatment also receive PITC for HIV.
- **Self-testing for HIV (HIVST)** is a process whereby a person who wants to know his or her status collects a specimen, performs a test, and interprets the results in private. HIVST is a screening test. It does not provide diagnosis, so confirmatory testing is required if the test result is positive. It is believed that HIVST may increase the number of people who test and know their status, although evidence of this is limited.<sup>98</sup>

In the interventions for key populations, both provider-initiated and client-initiated HIV testing and counselling work. Provider-initiated HIV testing and counselling is used to maximize opportunities to reach FSW/MSM/MSW/TG/PWID who come to health facilities for other services. The health facility staff should be trained on the importance of informed consent,

privacy, confidentiality, and possible adverse outcomes of disclosure of results, and be supervised and monitored very closely.

### Implementation Considerations

- Rapid HIV diagnostic tests at point of care facilitate access to testing, same-day results, and appropriate referral and follow-up.
- A mechanism should be devised to provide a consistent supply of kits from the MoH and prevent stock-outs.
- Service quality determines the uptake of HTC. It is critical to link to institutes that provide quality assurance at county levels.

### Settings for HTC

- **Stand-alone HTC** centres are facilities that are not attached to other health services and are usually targeted to reach key populations. These are specially located in hot spots frequented by key population and cater to key populations.
- **Outreach HTC** refers to services offered outside a clinical set up, mainly in hot spots and at times when key populations are available. These outreach HTC can be provided through a mobile vans, tents pitched in a hotspot, in of the rooms of a venue in the hot spot etc. The purpose of these HTC is to break the barriers related to distance and time by taking the service closer to where key populations are available and the time that is convenient.
- **Health-facility-based HTC** is located within an existing facility for all population like a government hospital or private hospital. The facility is not specially meant for KPs but KPs can access it. Sometimes KPs like accessing health-facility-based HTC, as it provides them anonymity.

### Recommendations and Guidance<sup>99</sup>

#### Special HTC Considerations for Key Populations

- Voluntary HTC should be routinely offered to all key populations in both community and clinical settings. MoH and NASCOP recommend routine voluntary testing every three months.

<sup>98</sup> WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

<sup>99</sup> WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

- Community-based HIV testing and counselling for key population with linkage to prevention, care, and treatment services is recommended in addition to PITC.
- Couples and partners should be offered voluntary HTC with support for mutual disclosure.

## 2.8.5 STI Prevention, Screening, and Treatment

STIs are caused by more than 30 bacteria, viruses, and parasites, and are spread predominantly by sexual contact, including vaginal, anal, and oral sex.<sup>100</sup> STIs include gonorrhoea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, HIV infection, and hepatitis B infection. Many STIs are curable, and others can be mitigated or modulated through treatment. Key populations are at higher risk for STIs due to unprotected sex, sex with multiple partners, and increased frequency of partner change. Several STIs may facilitate the sexual transmission of HIV infection.<sup>101</sup>

**The goal of STI screening and treatment for key populations is reduced STI incidence.**

**Elements of STI Screening and Treatment:** STI screening begins by a service provider recording a key population member's sexual history. This includes gathering information on the present illness, reproductive and medical history, and a behavioural risk assessment.

STI screening consists of medical examination by a doctor, which includes close inspection of the patient's genitals for signs of discharge, redness, lumps, or ulcers; and either etiological testing (lab tests) to identify the specific STI and/or syndromic diagnosis based on presence of STI symptoms. Screening for anal, oral, and genital STIs is recommended for all key populations. It is recommended that vaginal STI screening be conducted with a speculum and anal STI screening be conducted with a proctoscope.

STI treatment is based on laboratory results or syndromic diagnosis. Syndromic management is commonly used in Kenya to diagnose and treat symptomatic STIs. The algorithms for STI syndromic management are provided in Annex 2.10.1–9.

During STI screening and treatment, service providers are expected to ensure the 4Cs – Compliance (i.e., adherence), Condoms, Counselling, and Contact tracing (i.e., partner services). Service providers should provide correct and timely information on the importance of adherence to STI treatment; promote, demonstrate, and distribute condoms and latex-compatible lubricants; provide skills to negotiate condom use; counsel patients to prevent future STIs; and, if possible, identify and examine sex partners who may need treatment.

### Recommendations and Guidance<sup>102</sup>

- Periodic screening of key populations for asymptomatic STIs is recommended. MoH and NASCOP recommend screening every quarter. Quarterly screening provides opportunities to detect and treat STIs early, to conduct risk reduction counselling, and to distribute condoms and latex-compatible lubricants.
- In the absence of laboratory tests, symptomatic people from key populations should be managed syndromically, in line with national STI-management guidelines.
- STI services should be confidential and free of coercion, and service providers must obtain informed consent from patients before presumptive treatment.
- Periodic presumptive treatment (PPT) for asymptomatic STIs should be given to sex workers in high-prevalence settings that offer limited clinical services. PPT should be offered as free, voluntary, and confidential, and as a short-term measure where STI prevalence is high (>15% prevalence of *N. gonorrhoea* and/or *C. trachomatis* infection).
- Interventions need to be alert to provide STI control and management for PWID. People who inject drugs may also engage in sex work and men who inject drugs may have sex with other men and sex workers, and thus may face higher STI risks.<sup>103</sup>

<sup>100</sup> WHO Media Center. 2013. Sexually Transmitted Infections. Fact Sheet no. 110. <http://www.who.int/mediacentre/factsheets/fs110/en/>

<sup>101</sup> Fleming DT and Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sexually Transmitted Infections. 1999;75(1):3. <http://sti.bmj.com/content/75/1/3.long>

<sup>102</sup> WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

<sup>103</sup> Polling Booth Surveys, NASCOP 2014

Special Considerations for MSM/MSW/TG STI Screening<sup>1</sup>**Anal STI screening**

For men who have sex with men and transgender women, receptive anal sexual practices such as receptive fingering, toy insertion, or oral-anal sex are independent risk factors for anal gonorrhoea and chlamydia, even in men who use condoms for receptive anal intercourse. So, while any anal symptoms (e.g., bleeding, itching, discharge, pain) should prompt anal examination and testing, all MSM/MSW/TG should have anal swabs. MSM/MSW/TG with HIV are at high risk of anal STIs. Patient self-collection of an anal swab has been shown to be acceptable and effective at detecting anal gonorrhoea and chlamydia. Anal screening for cytological abnormalities or HPV infection is not recommended until more data is available on the reliability of screening methods, the safety of and response to treatment, and programmatic considerations.

**Bacterial STI testing technology at the urethra, throat, and anus**

NAAT (nucleic acid amplification tests) are highly sensitive and robust tests, which have been validated for use in urethral, rectal, and urine samples for gonorrhoea and chlamydia testing. However, gonococcal NAAT are subject to cross reactions from non-*Neisseriae* and non-gonococcal *Neisseriae* species, so laboratory best practice recommends initially positive gonococcal NAAT samples undergo supplemental NAAT targeting different part(s) of the gonococcal genome before test results are issued. Caution is advised when interpreting gonococcal NAAT results

especially from non-genital sites. The individual and public health significance of a positive chlamydia throat test has not been determined, so routine throat chlamydia testing is not recommended until there is further evidence.

**Herpes simplex (HSV) type-specific serology**

HSV-1 and HSV-2 infections are highly prevalent in MSM, and, with or without symptoms, increase the risk of acquiring and transmitting HIV. People with HIV infection are at increased risk of chronic, disabling mucocutaneous ulcers and other complications. Therefore, some experts recommend routine HSV serological testing for MSM. Only type-specific HSV glycoprotein G antibody tests should be used; no other serological test accurately differentiates between HSV-1 & -2 antibodies. HSV-seropositive MSM, especially if antibody to HSV-2 is present, should be informed of the increased risk of acquiring or transmitting HIV and should be taught to recognise the symptoms of anogenital herpes, including prodrome and other mild and nonspecific symptoms.

MSM/MSW/TG who do not have symptoms of STIs are the focus of these guidelines but they also apply to testing at anatomical sites other than the location of any current symptoms. Gonorrhoea, syphilis and chlamydia frequently do not produce symptoms regardless of the anatomical site of infection. Therefore, after behavioural risk assessment and appropriate counselling, it is

important to offer comprehensive screening to all MSM/MSW/TG.

**Recommendations:**

1. At least once a year: all men who have had any type of sex with another man in the previous year should be offered all of the following STI tests in the following ways:
  - Pharyngeal swab - Gonorrhoea culture
  - Anal swab - Gonorrhoea culture/NAAT\* and Chlamydia NAAT
  - First catch urine - Chlamydia NAAT
  - Serology -
    - HIV
    - Syphilis
    - Hepatitis A, if negative immunise
    - Hepatitis B, if negative immunise
    - Hepatitis C, (if HIV+ or injecting drug use)
2. More frequent testing:
  - 3-6 monthly testing is recommended for men who:
    - a. have episodes of unprotected anal sex
    - b. have more than 10 partners in the past six months
    - c. attend sex-on-premises venues (SOPVs)
    - d. use recreational drugs or
    - e. seek partners via the internet
3. Repeat testing: People diagnosed with chlamydia or gonorrhoea should be retested in 3 months after treatment.
4. Consider Herpes simplex virus (HSV) type-specific serology.

\* NAAT = *Nucleic acid amplification test* (e.g., PCR, LCR, SDA, TMA)

## STI Management and Clinical Services for Key Populations

Effective prevention and treatment of STIs among key populations requires attention to both symptomatic and asymptomatic infections. STI screening consists of either etiological testing (lab tests) to identify the specific STI and/or syndromic diagnosis (presence of STI symptoms).

**Components in the Prevention and Treatment of STIs in Key Populations:** Implementing partner clinics should have the following two components:

- **Management of symptomatic infections** – using national & WHO syndromic management flowcharts and laboratory diagnoses where available (Annex 2.10)
- **Screening and management of asymptomatic infections** – quarterly history taking, physical examination, and simple laboratory diagnostics (where available):
  - ▶ Treatment for asymptomatic gonococcal and chlamydial infections at the first visit and repeated every six months
  - ▶ Semi-annual serologic screening for syphilis

### Elements of STI management include

- symptomatic treatment through Syndromic Case Management (SCM)
- presumptive treatment
- Regular Medical Check-up (RMC) once every quarter
- six-monthly syphilis screening
- for MSM and sex workers, lab testing for STIs as and when required
- linkages/referrals for specialized treatment

## Implementation Consideration

Planning for STI services should be done with the key population and should be contextualized to the local situation.

- Mainstream STI treatment should be accessible and responsive to the needs of key populations
- In many countries where key populations are very marginalised, targeted standalone services for key population should be considered including outreach and peer support

- Active referral networks should be established and screening and testing programmes should be integrated with other services used by key populations.

- STI diagnosis and treatment services should be co located with HIV services used by key populations

Special attention should be paid to ensuring **community-friendly STI service delivery** through

- clinicians with the right attitude towards the community
- availability of services as per the needs of the community (e.g., late-night access)
- accessibility of services at optimal location (i.e., not too far from the major sex work sites, not requiring extensive travel)
- basic infrastructure (for examination and equipment)
- confidentiality between the clinic team and the community

**The following packages of STI/HIV services are to be provided:**

- Health promotion and STI prevention activities, such as promoting correct and consistent use of male condoms (and female condoms where available) and water-based lubricants and other safe sexual practices
- Provision of free male condoms (and female condoms if available) and lubricants
- Immediate diagnosis and clinical management of genital, oral, and anal STIs (Syndromic Case Management – see Annex 2.10 STI Screening Algorithms)
- Use of speculums to screen vaginal STIs
- Use of protoscopes to screen anal STIs
- Provision of STI medicines

- Health education and counselling for treatment compliance, correct and consistent use of condoms, and regular partner treatment
- Periodic check-ups, syphilis screening, and treatment of asymptomatic infections
- Partner management programmes (i.e., contact referral)
- Follow-up services
- Counselling support for seropositive persons
- Prophylaxis and treatment of simple opportunistic infections (OIs)
- Referral links to HTC, HIV care and support, and other relevant services

## 2.8.6 HIV Care and Treatment

HIV care and treatment includes interventions to maintain the health and well-being of HIV-positive individuals.<sup>104</sup>

The goal of HIV care and treatment is to restore the immune systems, reduce HIV- and AIDS-related morbidity and mortality, improve quality of life, decrease viral load, and reduce HIV transmission to partners of key population members.<sup>105</sup> HIV-positive key population members must have access to HIV care and treatment in line with national guidelines.

**Elements of HIV Care and Treatment:** Key populations should have access to a core package of HIV care and treatment services that include assessments for staging and CD4 count, antiretroviral treatment for all eligible individuals (based on WHO staging), management of opportunistic infections, Positive Health, Dignity, and Prevention (PHDP) interventions, palliative care, and home-based care.

The use of ART for HIV in key populations should follow the same general principles and

recommendations as for all adults.<sup>106</sup> They should have the same access, as well. People in key populations may experience discrimination and marginalization that can impede their access to health care, including treatment for HIV. It is important to ensure that people from key populations have equitable access to HIV treatment and care.

Even after initiation of ART, the utility of many of these interventions will remain and should be maintained throughout treatment. A follow-up mechanism should be developed to ensure that the drop-out rate is minimized while maintaining principles of confidentiality.

### Implementation Considerations

- **Ensure Accessible Services:** To increase HIV care and treatment access by key populations, it may be beneficial to modify the working hours of comprehensive care centres to flexibly accommodate key population members' varied schedules, train service providers on delivering 'key-population-friendly' services, and create demand for the services through targeted outreach.
- **Ensure Uninterrupted Supply of ART and/or OI Prophylaxis:** Key population members are highly mobile within and between Counties. Due to this high mobility, they may need to be provided with ARV supplies that cover longer periods of time or be linked to other clinics offering ARVs to ensure an uninterrupted supply of drugs.
- **Adherence among Key Populations:** Adherence to ART is key to HIV suppression, reduced risk of drug resistance, improved overall health, and decreased risk HIV transmission. This underscores the importance of monitoring adherence among key populations. Adherence counselling and support groups need to be provided to address the challenges in adherence. Peer educators and outreach workers may need to follow-up on individuals who skip doses or stop ART altogether.
- **Positive Health, Dignity, and Prevention:** PHDP is designed to reduce HIV transmission between sex partners and increase well-

<sup>104</sup> NASCOP. 2010. National Guidelines for HIV/STI Programs for Sex Workers. Nairobi: NASCOP. <http://nascop.or.ke/library/Marps/Sex%20Worker%20Guidelines.pdf>

<sup>105</sup> WHO. 2009. Priority Interventions: HIV Prevention, Treatment and Care in the Health Sector. Geneva: WHO. [http://www.who.int/hiv/pub/priority\\_interventions\\_web.pdf](http://www.who.int/hiv/pub/priority_interventions_web.pdf)

<sup>106</sup> WHO. 2013. Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf)

being of the person living with HIV. For key populations, PHDP may need to be modified to accommodate certain key population parameters. For example, the primary source of income for sex workers is the exchange of sex for money. As such, they may not be able or willing to leave sex work. It therefore follows that tailored risk-reduction counselling for HIV-positive sex workers will be a crucial component of PHDP and should focus on reducing risk of HIV transmission through

- uninterrupted supply of condoms and lubricants
- skills building for consistent and correct male and female condom and latex-compatible lubricant use
- 100% condom use with all sex partners
- risk assessment and risk-reduction counselling to reduce the number of sex partners (although this may be difficult for those in the sex trade) and other HIV risk behaviours (i.e., unprotected sex, sharing of drug injecting paraphernalia)
- provision of services to expand choices beyond sex work. HIV-positive sex workers suffer dual stigma of being HIV-positive and a sex worker. Tailored psychosocial individual or group support may be warranted to address these issues.

- **Screening and Treatment for Alcohol and Drug Abuse:** Key populations often experience multiple and cross-cutting levels of risk (e.g., drug and alcohol abuse) over and above their primary vulnerabilities. Alcohol and drug use interfere with adherence to ARVs, and some illicit drugs are known to result in adverse reactions when combined with ARVs. Therefore service providers should screen key-population clients for alcohol and drug abuse using the tools provided in Annexes 2.8 and 2.9.

### Elimination of Mother-to-Child Transmission

The transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery, or breastfeeding is called mother-to-child transmission (MTCT). The global community has committed itself to accelerate progress for the elimination of mother-to-child HIV transmission (EMTCT) through an initiative with the goal to eliminate new paediatric HIV infections by 2015

and improve maternal, newborn, and child survival and health in the context of HIV.<sup>107</sup>

Elimination of mother-to-child transmission of HIV, also known as prevention of vertical transmission, refers to interventions to prevent transmission of HIV from a mother living with HIV to her infant during pregnancy, labour, or delivery, or while breastfeeding. EMTCT focuses on early initiation of ART in the mother and assuring the mother's health.

WHO recommends a **four-pronged approach** to a comprehensive EMTCT strategy:

1. Primary prevention of HIV infection among women of childbearing age
2. Preventing unintended pregnancies among women living with HIV
3. Preventing HIV transmission from women living with HIV to their infants
4. Providing appropriate treatment, care, and support to mothers living with HIV, their children, and families.

The third prong focuses on direct interventions to prevent vertical transmission, which include HIV testing and counselling, ART, safe delivery, safer infant feeding, postpartum interventions in the context of ongoing ART, early infant diagnosis, and final diagnosis for HIV-exposed infants. Prong Four is linkage of the mother and child to appropriate care and treatment. All pregnant women from key populations should have the same access to EMTCT services and should follow the same recommendations as women in other populations.

### Recommendations and Guidance

All pregnant women in key population groups

- All pregnant and breastfeeding women living with HIV should initiate triple antiretrovirals, which should be maintained at least for the duration of risk of mother-to-child transmission. Women meeting treatment eligibility criteria should continue ART for life (CD4 <500 cells/mm<sup>3</sup>).

<sup>107</sup> WHO. Mother-to-Child Transmission of HIV. <http://www.who.int/hiv/topics/mtct/en/>

- For programmatic and operational reasons, particularly in generalized epidemics, all pregnant and breastfeeding women living with HIV should initiate ART and maintain it as lifelong treatment (option B+).

## 2.8.7 Tuberculosis Screening and Referral to Treatment

Tuberculosis (TB) is a bacterial disease caused mainly by *Mycobacterium tuberculosis*.<sup>108</sup> TB is transmitted from person to person via moisture droplets from the throat and lungs of people with active respiratory disease (smear-positive sputum).

People most susceptible to TB are those with a weakened immune system, such as people living with HIV and AIDS and drug and alcohol abusers. Despite being preventable and curable, TB is the leading cause of HIV-associated mortality, accounting for one of every five HIV-related deaths. The risk of developing TB is 30-times higher among people living with HIV than among people who do not have HIV. Key populations, who are more likely to be HIV-positive and/or abuse alcohol and drugs, have increased susceptibility to TB. Therefore, service providers should screen both HIV-positive and negative key population for TB, using the WHO-recommended four-TB-symptom screening algorithm—that is, current cough, fever, night sweats, or weight loss—at each contact with a health care worker. Early detection and treatment of TB will decrease the risk of further TB transmission. Completing TB treatment is critical to reducing mortality and avoiding the development and spread of drug resistant TB. It is important to provide a supportive, non-judgemental and non-discriminatory environment that enables people from key populations to complete treatment, provides additional adherence support measures to improve treatment outcomes, and reduces risk of continued TB transmission. Timely initiation of ART significantly reduces the risk of mortality from HIV-associated TB. As TB is one of the most common AIDS-defining illnesses, all those with presumptive or diagnosed TB should be offered HIV testing and counselling as a priority so that those testing positive can start ART as soon as possible, in any case no later than eight weeks after initiation of TB

treatment, regardless of CD4 count.<sup>109</sup>

### Elements of Tuberculosis Screening and Referral to Treatment:

Programmes serving key populations need to ensure access to integrated, client-centred services, preferably at the initial point of care, including TB screening, prevention, and treatment, and support to treatment adherence.<sup>110</sup> Programmes offering services to key populations should carry out TB screening and should support key populations throughout the cycle of care from TB prevention through diagnosis and treatment. This can be done through static clinic or through outreach clinics. The programmes should teach the key populations to recognise TB symptoms and understand TB transmission, as well as to appreciate the importance of infection control and cough etiquette. Clinics that do not offer diagnosis and treatment can refer the key populations to a diagnosis and treatment centre. Follow-up of such clients becomes the responsibility of the key-population-serving organisation. Alcohol dependence, active drug use, and mental health disorders should not be used as reasons to withhold TB treatment.

### Implementation Considerations

- Key-population-serving programmes should map and identify TB diagnosis and treatment programmes in their location and develop formal linkages for referral and follow-up.
- Clinical staff in the key-population-serving organisations should be trained to provide quality TB and HIV care.
- Every key-population-serving clinic should have a TB infection control plan.
- Mainstream TB services should be sensitised to be responsive to the needs of key populations.

<sup>108</sup> WHO. Health Topics. Tuberculosis. <http://www.who.int/topics/tuberculosis/en/>

<sup>109</sup> WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

<sup>110</sup> WHO. 2008. Policy Guidelines for Collaborative TB and HIV Services for Injecting and Other Drug Users: an Integrated Approach. Evidence for Action Technical Papers. Geneva: WHO. [http://whqlibdoc.who.int/publications/2008/9789241596930\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241596930_eng.pdf).

## Desirable Biomedical Interventions

### 2.8.8 Viral Hepatitis Screening, Vaccination, Treatment, and Care

Hepatitis B virus (HBV) has had a significant impact on key populations, especially men who have sex with men, transgender women, and people who inject drugs. The major modes of HBV transmission include sexual intercourse, unsterile medical injections, blood transfusions, and injecting drug use. Although hepatitis C virus (HCV) is rarely transmitted sexually, it is of significant concern to people who inject drugs. Among HIV-positive PWID, approximately 75% are co-infected with HCV.

Both HBV and HCV can cause acute inflammatory hepatitis, which can result in fulminant liver failure. Chronic infection can result in liver fibrosis and ultimately cirrhosis and hepatocellular carcinoma—conditions resulting in increased mortality. Additionally, they can complicate HIV treatment, and HCV can accelerate the progression of HIV disease.

For people who inject drugs, sharing contaminated needles and syringes is the most common mode of HCV transmission, although sharing other equipment, such as spoons and filters, has also been associated with HCV transmission. HCV is substantially more infectious than HIV, and many people who inject drugs are repeatedly exposed to HCV. This results not only in higher incidence rates but also in reinfection after clearance of HCV. HCV is more difficult to transmit through unprotected sexual intercourse than HIV. There is evidence that, among people who are co-infected with HIV and HCV, traumatic sexual practices or ulcerative STIs are conducive to sexual transmission of HCV.

**HBV vaccination is inexpensive, safe, and effective.** It produces an immune response adequate to protect against infection in close to 100% of children and about 95% of adults, lasting at least 10 years. The risk of acute infection is very low in fully vaccinated individuals. As a result of the preservation of the (immune memory) response and apparent immuno-protection, there is no need to administer a booster in routine immunization programmes.

**Elements of HBV vaccination:** The standard schedule for HBV vaccination is at 0, 1, and 6 months, while the rapid schedule is at 1, 7, and 21 days.

Men who have sex with men and transgender women should be included in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage (in line with existing WHO guidelines). Due to social instability and poor access to health care, PWID may be less likely than many other people to complete a six-month schedule. Shorter vaccine schedules for PWID should promote adherence and may also encourage health services to take advantage of opportunities for vaccination. A higher-dose HBV vaccine should be used with the rapid regimen.

- HBV vaccine is already strongly recommended for PWID, per WHO guidelines.
- The priority for any regimen is delivery of the first dose of vaccine.
- Completion of three doses is more important than following a specific schedule. A missed dose should be given at the earliest opportunity without re-initiating the regimen.
- Individuals with inadequately treated HIV or with chronic HCV may have suppressed immunogenicity and may benefit more from the standard regimen.
- Both rapid and standard HBV vaccine regimens should be offered to PWID.

Services that could provide vaccination on a rapid schedule include drop-in centres and drug treatment sites, needle and syringe programmes, and other harm-reduction services that engage regularly with key populations.

### 2.8.9 Mental Health

About four out of five people in low- and middle-income countries who need services for mental, neurological, and substance use conditions do not receive them. Even when available, the interventions are often neither evidence based nor of high quality.

Stigma and discrimination against key populations have been described as key drivers of poor physical and mental health outcomes across diverse settings. In addition to being disproportionately burdened by STI and HIV, key populations, especially MSM and transgender persons, experience higher rates of depression, anxiety, smoking, alcohol and substance abuse, and suicide as a result of chronic stress, social isolation, and disconnection from a range of health and support services. From an HIV-prevention standpoint, alcohol and substance use/dependence increase HIV-risk by diminishing inhibitions. Selling sex to maintain drug supply also increases the risk for HIV infection.

### 2.8.10 Family Planning

Family planning is the process by which women and men make informed choices about their sexual and reproductive lives, including the timing and spacing of births, which can improve their own health and substantially increase their child's chances of survival and good health.<sup>111</sup>

Family planning includes barrier methods such as condoms and diaphragms, contraceptive pills (combined or progestin-only therapy), injectable contraceptives, and intrauterine devices (IUD). For female sex workers and females who inject drugs, the goal is to provide easy, free or affordable access to family planning services. Existing data suggest a large unmet need for family planning among women. Since female sex workers and women who inject drugs are highly stigmatized and engage in riskier sex, their unmet needs are likely to be higher.

**Elements of Family Planning:** Service providers should emphasize the need for dual protection (using both condoms and another FP method), since condoms are the only family planning method that can prevent HIV/STIs. Service providers should offer provider-initiated testing and counselling on a quarterly basis to HIV-negative female sex workers, females who inject drugs, and those with unknown status. Targeted outreach should be provided to female sex workers and females who inject drugs to increase correct knowledge of, and demand for, family planning.

Provision of family planning should be aligned to national reproductive health guidelines.

### 2.8.11 Post-Abortion Care

Several studies have shown that one of the most effective ways to curb abortion-related mortality and morbidity, regardless of prevailing abortion laws, is to provide high-quality post-abortion care.

The goal of post-abortion care is to treat complications that arise from unsafe abortions and counsel the women on how to use family planning methods to prevent future unintended pregnancies and unsafe abortion. 23% of female sex workers in Kenya reported having had an abortion in their lifetime, with the majority reporting that they carry out their own abortions. The abortion statistics for females who inject drugs is unknown.

**Elements of Post-Abortion Care:** Post-abortion care is the care given to women who have had an unsafe abortion. It consists of the emergency treatment of complications from an unsafe abortion, family planning counselling/services, and provision of PITC. Post-abortion care should be provided to each sex worker when needed, with compassion and in line with national guidelines.

### 2.8.12 Cervical Cancer Screening and Treatment

Cervical cancer screening is the process of identifying precursor/precancerous lesions (CIN) or cancerous cells in the cervix. Human papillomavirus (HPV) is an STI and etiological agent of cervical cancer cases. Although there are over 100 HPV types, 20 are known to be cancer-causing, and of these, HPV 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide.

Several techniques are used for cervical cancer screening to identify HPV or CIN. Papanicolaou smear (pap smear) is the collection of a sample from the cervix to test for HPV infection. CIN or precursor cells can be identified through visual inspection of the ectocervix washed with acetic acid or visual inspection of an iodine painted cervix. Cervical cancer screening leads to early detection and treatment of CIN, decreasing the incidence of cervical cancer.

<sup>111</sup> NASCOP. 2010. National Guidelines for HIV/STI Programs for Sex Workers. Nairobi: NASCOP. <http://nascop.or.ke/library/Marps/Sex%20Worker%20Guidelines.pdf>

Risk factors that increase acquisition of HPV include multiple partners and infection with other STIs, including HIV. Risk factors that increase progression to precursor lesions or cancer include infection with HPV 16 or 18, family history of cervical cancer, immunosuppression (i.e., HIV-positive status, pregnancy), diabetes mellitus, and smoking. Sex workers are at greater risk for acquiring HPV and more likely to be HIV infected, increasing their risk of progressing to cervical cancer.

It is recommended that cervical cancer screening and treatment be offered to all female sex workers as part of the desirable package of services.

**Elements of Cervical Cancer Screening:** Cervical cancer screening should be conducted in line with national guidelines. The type of screening technique will be determined by service providers and comply with national standards. Some methods (e.g., pap smear) may not be cost-effective for routine administration, therefore other methods (e.g., visual inspection) may be warranted. It is important that a routine (e.g., annual) cervical cancer screening schedule is created for SWs based on local epidemiology and available resources.

**Note:** An HPV vaccine exists to prevent the four types of HPV linked to 80% of cervical cancer cases. Once the vaccine is available, service providers should consider vaccinating sex workers, females who inject drugs, and their female children.

### 2.8.13 Screening for Anal and Other Cancers

Screening for breast cancer, ano-rectal, and prostate cancer should be part of routine care, and links to treatment services should be provided.<sup>112</sup> People infected with HIV are at least 20 times more likely to be diagnosed with anal cancer than uninfected people. Like cancer of the cervix, anal cancer is associated with human papillomavirus (HPV). Screening can be performed for anal cancer and its precursors, known as anal high-grade squamous intraepithelial lesions (HSIL), particularly for men who have sex with men, transgender people and other people from key populations who are more likely to engage in anal sex.

### 2.8.14 Emergency Contraception

Emergency contraception (EC)—also referred to as the ‘second option’ or the ‘morning-after pill’—is provided to women who are not currently using a contraceptive method and not already pregnant, to prevent pregnancy after unprotected vaginal sex. Female sex workers and females who inject drugs should have access to EC due to their increased likelihood of engaging in unprotected sex.

Currently no guidance exists on how frequently EC can be used. Therefore, service providers should use caution and monitor how many times EC is used by female sex workers and females who inject drugs, and encourage them to use long-term family planning methods (e.g., contraceptive pills, IUD, etc.), as EC is NOT a long-term family planning method.

#### Elements of Emergency Contraception

**Provision:** Emergency contraception should be provided for free or at an affordable cost to female sex workers. When prescribing EC, service providers should

1. establish eligibility (exposure within last 5 days, not currently using a contraceptive method, or already pregnant);
2. provide EC (1- or 2-day dose);
3. provide family planning counselling and FP options;
4. promote, demonstrate, and distribute condoms and lubricants; and
5. conduct risk-reduction counselling and skills building to reduce unprotected sex.

**Note:** Programmes targeting sex workers should have strong links with health providers who prescribe and pharmacies that dispense EC without a prescription to ensure FSWs have access to EC within 120 hours of exposure.

<sup>112</sup> WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

## 2.9

### REFERRAL MECHANISMS

Many of the key interventions, particularly biomedical interventions, might be provided through referrals and linkages to appropriate local service providers or public facilities. In such cases, implementing organisations should a) ensure that the services are appropriate and acceptable to key populations, b) provide an appropriate range of services, and c) have effective referral and linkage systems to facilitate the use of these services by key populations reached by the programme. This entails

- identifying appropriate local service providers through community consultations and local assessments,
- developing mutually supportive relationships between the implementing organisation, the community members, and the service providers, and
- establishing an effective system for making and tracking referrals and service delivery.

In some cases, implementing organisations might require technical assistance in identifying and assessing appropriate service providers.

**A referral network includes making and tracking referrals, establishing a referral directory, and monitoring the referral process.**

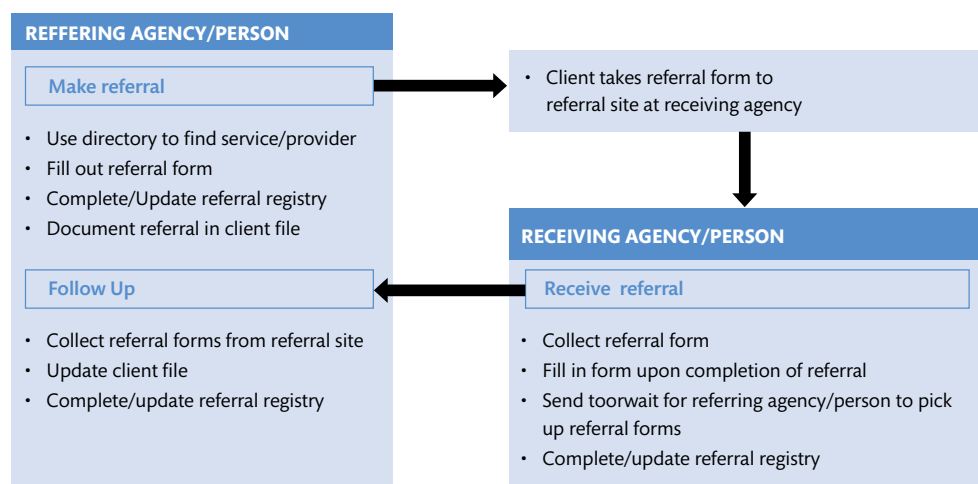
Referral networks are usually developed for a defined, smaller geographic area, and not for the entire country or province. The referrals process ensures the HIV/STI-related needs of the KP are assessed and s/he is helped to access the identified services. Referrals are strengthened when a structured understanding describing the relationship between organisations/service providers is developed. A structured understanding ensures organisations/ providers collaborate and avoid duplication of services, improving the efficiency of programme delivery.

#### Developing a Referral Network

To create a referral network, service providers will

- **Map the catchment area**, noting entry points to services (sensitized staff, time of day, etc.), possible barriers to services (cost, location, etc.), and stakeholders/gatekeepers that need to be contacted (madams, law enforcement, etc.).
- **Define the target population** (type of key population, structure, etc.) and geographic coverage area.
- **Identify a coordinating body** (most likely, a governmental body) that will manage and monitor the referral network (who was referred, when, and to what services) in the geographic coverage area.
- **Identify the needs** to be met by the referrals (i.e., components of the HIV/STI package not provided by the individual referring programme).
- Identify and **sensitize the staff of organisations** to provide non-judgmental services.
- Develop a **structured understanding** between organisations within the referral network.
- Create a **referral directory** that contains the name, location, hours of operation, services provided, cost, and point person of each organisation within the referral network.
- Produce a **standard referral form and register** to be used by all organisations within the referral network to track referrals (NACC- or NASCOP-approved forms).
- Create a **feedback loop** for client and programme follow-up on the referral service and process.
- **Monitor the referral system**, documenting the number of successful referrals (number of KPs who are successfully linked to the service they were referred to and received the service). The referral documentation process is illustrated in Figure 10.

FIGURE 10: Referral Documentation Process



### Key Issues in Establishing Referral Networks

To ensure successful implementation of a referral network, it is important that service providers

- mobilize the target population to use the services within the referral system (demand creation);
- ensure that organisations in the referral network are capable of providing KP-sensitive services, including addressing issues of capacity, accessibility, and acceptability;
- ensure confidentiality between organisations;
- ensure documentation of the referral process (who was referred, from where, to where, and was the referral successful); and
- enlist feedback on services from the target population and organisations in the referral network.

## 2.10

### STRUCTURAL INTERVENTIONS

#### 2.10.1 Introduction

HIV-prevention efforts with key populations cannot fully succeed without addressing underlying drivers of HIV risk and vulnerability. In addition to behavioural and biomedical approaches, which target high-risk individuals and groups, HIV-prevention interventions must simultaneously address structural factors. For key populations, many factors that influence a person's risk are largely outside that person's control. Particularly for key populations, social, legal, structural, and other contextual factors both increase vulnerability to HIV and obstruct access to HIV services. Such factors include punitive legislation and policing practices, stigma and discrimination, poverty, and violence. By limiting access to information, prevention services and commodities, and care and treatment, these factors affect how well individuals or populations can protect themselves from, and cope with, HIV infection.<sup>113</sup> Structural interventions address social, economic, political, and environmental factors that affect individual or

<sup>113</sup> WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1) Con

group HIV risk and vulnerability,<sup>114</sup> and typically involve at least one of the following: effecting policy or legal changes, challenging harmful social norms, catalyzing social and political change, and empowering communities and groups.<sup>115</sup> These approaches must be implemented in combination with behavioral and biomedical approaches and should be based on scientifically derived evidence and wisdom and ownership of communities.<sup>116</sup>

Structural approaches to HIV prevention have been employed throughout the epidemic, but such strategies have only recently emerged as an internationally recognized, distinct area of HIV prevention. A growing body of literature now describes and categorizes structural approaches and integrates these approaches into comprehensive HIV prevention with key populations.

Structural approaches to HIV prevention should be implemented in a contextually sensitive way. Most interventions addressing structure need collaborative effort and networking skills and may be beyond the scope of an individual implementing partner /CBO. Implementers should, therefore, network and collaborate with organisations that can address these issues and develop a comprehensive structural intervention strategy for the specific key population in the local area.

#### Essential Structural Interventions

- Shaping policy and creating enabling environments
- Reducing stigma and discrimination
- Empowering the community, including ownership and leadership
- Violence prevention and response

## 2.10.2 Shaping Policy and Creating Enabling Environments

Sixty percent of countries report having laws, regulations or policies that are barriers to effective

HIV services for key populations. Kenya is one such country.<sup>117</sup> Law and policies can help to protect the human rights of key populations. WHO recommends that governments should establish antidiscrimination and other rights-respecting laws and policies to protect key populations and reduce their vulnerability to HIV infection.

- Policy-makers, parliamentarians, religious leaders, and other public figures should work together with civil society and sex workers' organisations to confront stigma, discrimination, and violence against sex workers, and abolish punitive legal and social norms and practices that stigmatize and marginalize sex workers. Representatives of UN agencies should do everything possible to support these national processes.
- Programmes should be put in place to provide legal literacy and legal services to sex workers so that they know their rights and applicable laws, and can be supported to access the justice system when aggrieved.

FIGURE 11: **HIV-Prevention Policy to Address a Regulatory**

In line with provisions of the Kenya Constitution (Article 43 (1) (a), which affirms every citizen's right to health



No specific policy and legal enforcement tool to address needs of key population identified by KNAPS III ETR



Policy envisions to create an enabling environment wherein all key populations can access prevention and care services, thereby supporting the HIV prevention goal of Kenya

<sup>114</sup> Gupta GR et al. Structural approaches to HIV prevention. *Lancet*. 2008;372(9640):764-75. doi: 10.1016/S0140-6736(08)60887-9. [http://bibliobase. sermais.pt:8008/BiblioNET/Upload/PDF6/004743\\_Lancet.pdf](http://bibliobase.sermais.pt:8008/BiblioNET/Upload/PDF6/004743_Lancet.pdf)

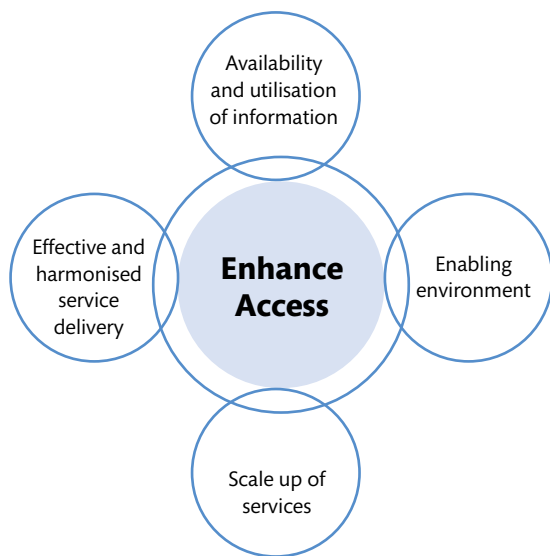
<sup>115</sup> Auerbach J. Transforming social structures and environments to help in HIV prevention. *Health Aff (Millwood)*. 2009;28:1655-doi: 10.1377/hlthaff.28.6.1655. <http://content.healthaffairs.org/content/28/6/1655.full.pdf+html>

<sup>116</sup> Merson MH et al. The history and challenge of HIV prevention. *Lancet*. 2008;372(9637):475 - 488. doi:10.1016/S0140-6736(08)60884-3. [http:// multimedia.thelancet.com/pdf/press/hiv1.pdf](http://multimedia.thelancet.com/pdf/press/hiv1.pdf)

<sup>117</sup> UNAIDS. 2013. Global Report: UNAIDS Report on the Global AIDS Epidemic 2013. Geneva: UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/ documents/epidemiology/2013/gr2013/UNAIDS\\_Global\\_Report\\_2013\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf)

HIV programmes should take affirmative steps to promote the universality of human rights for key populations, including their rights to health, dignity, and life free from violence, discrimination, and stigma. The Kenya National Strategic Plan recognizes key populations' heightened HIV risk and vulnerability and ensures that integrated, high-quality health services are available, affordable, and accessible for sex workers, MSM, and PWID.

**FIGURE 12: Policy Objectives for Enhanced Access**



NACC and NASCOP under the Ministry of Health have developed a draft HIV-prevention policy for key populations and over a period of 15 months through a consultative and evidence-based process that included stakeholders from government ministries, departments, and agencies; development partners; faith-based organisations; civil society organisations; key population networks; and key population representatives. Regional validation workshops were organized with key population groups to validate the guiding principles and policy objectives. This policy, when approved, will provide an enabling environment for key populations to access the highest-attainable health care. They have drafted a Key Population HIV Prevention Policy in line with the provisions of Article 43(1)(a) of the Constitution of Kenya, which states that every citizen has the right to the highest-attainable standard of health; various relevant international human rights instruments to which Kenya is a party to and therefore are a part of country's legal system

by virtue Article 2(6) of the Constitution of Kenya which states that any treaty or convention ratified by Kenya shall form part of the law of Kenya; and the HIV and AIDS Prevention and Control Act no. 14 of 2006, which prohibits discrimination against people living with HIV (PLHIV).

The reason to have a policy is premised also on a need identified under the KNASP III end-of-term review, which found that there are no specific policy and legal enforcement tools to address the needs of the key populations (Figure 11). The absence of such tools impedes scale-up of interventions aimed at reducing the spread of HIV among key population.

***The policy envisions creating a facilitating environment where all key populations in Kenya can access HIV-prevention, care, support, and treatment programmes using a rights-based approach.***

Overall objective: To enhance access to HIV prevention, treatment, and care and support programmes and services among key populations in Kenya.

Four objectives for enhanced access, as illustrated in Figure 12

**Policy Objective 1:** Facilitate the generation and synthesis of information on subpopulations for evidence-based key population programmes in the country.

**Policy Objective 2:** Address barriers to scaling up comprehensive key population programmes.

**Policy Objective 3:** Increased access to scaled-up services and comprehensive HIV combination prevention programmes.

**Policy Objective 4:** Facilitate stakeholder coordination to harmonized national and county-level HIV response to key populations.

This policy will ensure that key populations' access to health services and information improve.

### 2.10.3 Reducing Stigma and Discrimination

WHO recommends that health services should be made available, accessible, and acceptable to key populations based on the principles of avoidance of stigma, non-discrimination, and the right to health. Health care services are perceived as one of the highest perpetrators of stigma and violence. Complementary actions should be undertaken to reduce stigma related to HIV and sex work in health care settings and communities. Programmes should be put in place to sensitize and educate health care providers on non-discrimination and sex workers' right to high-quality and non-coercive care, confidentiality, and informed consent. Key population groups and organisations should be made essential partners and leaders in designing, planning, implementing, and evaluating health services.

#### Providing key-population-friendly services

It is important to make health services available, accessible and acceptable to key populations and tailor the services to their needs. Involvement of key populations in planning and designing the services including running the services can ensure acceptance. Some of the ways to make the services friendly are:

- Providing services under one roof so that the key populations do not have to go to different places for different services, like providing STI services or ARVs in the drop in centre
- Scheduling services hours that suit the key populations like extended hours during the weekend or clinics being open in the evening
- The services should be close to hot spots where it is accessible.
- Training the staff in the service centres to work with different key populations
- Taking steps to ensure that neighbours and law enforcement activities do not interfere with key populations access to services
- Involvement of key populations in delivery, promotion, and monitoring of services

#### Training and sensitizing health care workers

Many service providers may be unfamiliar with providing services to key populations; therefore it will be important to train these individuals on offering key-population-friendly health services. Service providers are provided with appropriate sensitivity training (through NASCOP) including attitudes and skills to strengthen their skills working with key populations with compassion and care. Service providers will be trained on addressing the HIV/STI behaviors of key populations, including anal sex, douching practices, oral sex, and injecting practices. Service providers will also be trained on other issues related to key populations, including sexual violence, legal issues, stigma, and discrimination. All service providers will be sensitized to ensure their attitudes (i.e., personal views, beliefs, judgments, etc.) do not dismiss the health needs of the key populations. Privacy and confidentiality of KPs must be maintained, unless they give consent for the information to be shared. In training service providers, the goal is to provide acceptable services that address the needs of the population while respecting their health and human rights. NASCOP has also developed a Learning Site in Mombasa to provide the health providers with hands-on training with key populations.

The implementers who run clinics for key populations should ensure that the health care providers in those clinics undergo sensitivity training as prescribed by NASCOP.

### 2.10.4 Empowering the Community, including Ownership and Leadership

Community empowerment is a collective process through which the structural constraints to health, human rights, and well-being are addressed by key populations to create social and behavioral changes and access to health services to reduce the risk of acquiring HIV.<sup>118</sup> The interventions delivered through a community empowerment model are sustained engagement with local key populations to raise awareness about their rights, establishment of community-led drop-in centres, formation of collectives that determine the range of services to

<sup>118</sup> WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

be provided, outreach, and advocacy. Community empowerment interventions seek to create a safe space, utilizing solidarity and collective efficacy to advocate for increased power and control in society, and to challenge power structures that deny that group control and justice.<sup>119</sup>

Key populations are essential partners and leaders in effective HIV and sexual health programmes, and for developing solutions that respond to the realities of the environments in which they live. As mentioned earlier, programmes that target key populations' HIV risks without addressing their societal causes are likely to have a limited impact. Structural interventions, such as community empowerment aimed at reducing the vulnerability of key populations, may enable key populations to have greater control over their conditions and thereby control their risk of acquiring infection.

Assessment of the effectiveness of two structural interventions in the Dominican Republic revealed that interventions that combine community solidarity and government policy show positive initial effects on HIV- and STI-risk reduction among female sex workers.<sup>120</sup> A study in India found that sex workers who were members of groups and participated in community mobilization activities had a lower prevalence of gonorrhea and/or chlamydia and syphilis compared to non-members. FSWs who were members of any peer group also reported significantly less experience of violence in the past six months compared to non-members.<sup>121</sup> Blanchard et al. found that community mobilization has benefits for empowering FSWs both individually and collectively. HIV prevention is strengthened by improving FSWs' ability to address psycho-social and community-level sources of their vulnerability.<sup>122</sup> Beattie et al. also found that community mobilization is central to HIV-prevention programming among FSWs, empowering them to better negotiate condom

use and access services, as well as address other concerns in their lives.<sup>123</sup> Inclusion of drug users as legitimate stakeholders in HIV-prevention programmes can increase programme effectiveness.<sup>124</sup>

### Community Empowerment, Ownership, and Leadership

The interventions delivered through a community empowerment model include sustained engagement with local key populations to 1) raise awareness about their rights, 2) facilitate meaningful participation, 3) establish key-population-led services, and 4) form collectives/networks and coalitions that determine the range of services to be provided. Community empowerment is a necessary component of key population interventions and should be led by key populations.

### Key Elements of Community Empowerment, Ownership, and Leadership

As illustrated in Figure 13, the process of community empowerment is, by definition, driven by the key population and hence should be designed and led by key populations. Successful programmes have empowered key populations and increased community ownership and leadership by educating the community about their rights, and creating community committees to formalize the community's meaningful participation in intervention.

### Raise Awareness on Rights

The first step to community empowerment is to ensure that the key populations value and accept themselves and their work or sexual orientation, and that they know their rights as humans and citizens of Kenya. Interventions should facilitate forums and spaces where key populations can reflect on their work, sexual identity, and issues of addiction, and understand that their identities are not wrong even though they have been made to feel otherwise by the society. The forums should ensure that the key populations understand their rights as humans and citizens of Kenya

119 WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

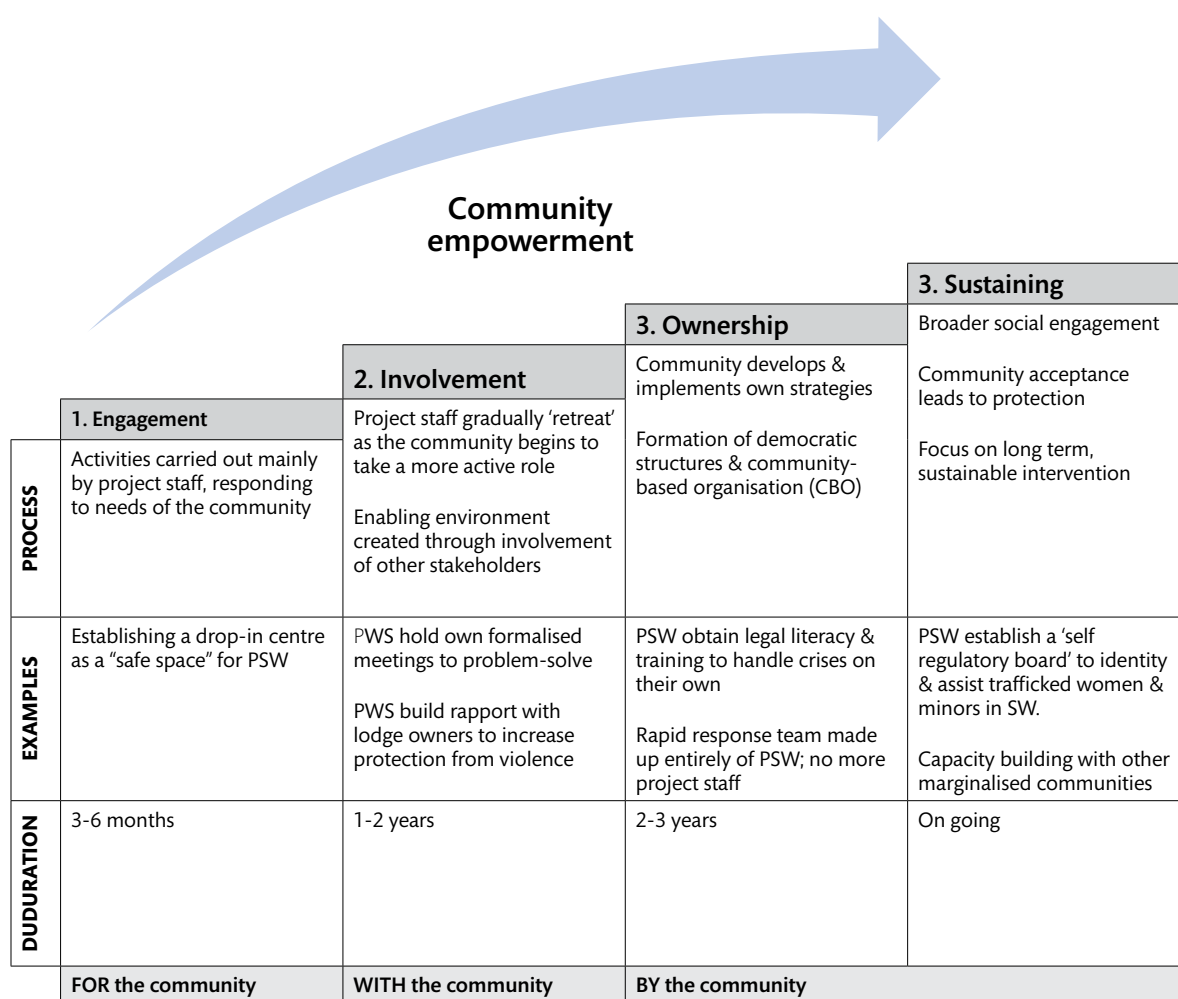
120 Deanna Kerrigan et al. Environmental - structural interventions to reduce HIV/STI risk among female sex workers in the Dominican Republic. American Journal of Public Health. 2006;96(1):120-5. doi: 10.2105/AJPH.2004.042200. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470438/pdf/0960120.pdf>

121 Bhattacharjee P et al. Understanding the role of peer group membership in reducing HIV-related risk and vulnerability among female sex workers in Karnataka, India. AIDS Care. 2013;25 Suppl 1:S46-54. doi: 10.1080/09540121.2012.736607. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4003574/pdf/caic25\\_S46.pdf](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4003574/pdf/caic25_S46.pdf)

122 Blanchard A et al. Community mobilization, empowerment and HIV prevention among female sex workers in south India. BMC Public Health. 2013;13:234 doi:10.1186/1471-2458-13-234 <http://www.biomedcentral.com/content/pdf/1471-2458-13-234.pdf>

123 Beattie T et al. Community mobilization and empowerment of female sex workers in Karnataka State, south India: associations with HIV and sexually transmitted infection risk. American Journal of Public Health. 2014;104(8):1516-25. doi: 10.2105/AJPH.2014.301911. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4103234/pdf/AJPH.2014.301911.pdf>

124 Des Jarlais DC. Structural interventions to reduce HIV transmission among injecting drug users. AIDS. 2000;14:S41. DOI: 10.1097/00002030-200006001-00006

FIGURE 13: **Stages of empowerment in Ashodaya's model of implementing community-based structural interventions (adapted from Reza-Paul et al. 2012)\***

\* Moore L et al. Community empowerment and involvement of female sex workers in targeted sexual and reproductive health interventions in Africa: a systematic review. *Globalisation and Health*. 2014;10:47. doi:10.1186/1744-8603-10-47. <http://www.globalizationandhealth.com/content/pdf/1744-8603-10-47.pdf>

and understand situations when such rights are violated and mechanisms for redress. Such spaces and forums also build collective solidarity and support mobilization to advocate for KPs and to challenge and change behaviors of powerful groups and institutions that deny them their rights.

### Meaningful Participation of Key Populations

Community empowerment is a process that takes significant time and effort, especially since in the Kenyan context sex work, same-sex relationships, and drug use are stigmatized and criminalized.

Hence it is important to respect and build trust with key populations. Understanding the needs and concerns of key populations and working with them throughout the process of developing and implementing an intervention are most important. The goal is to cultivate a programme that is eventually run entirely by key populations, and where key population led organisations are respected as partners by all implementers. If key populations are meaningfully engaged from the beginning of the project, then this transition is smooth.

**Meaningful participation means that key populations<sup>125</sup>**

- choose how they are represented, and by whom
- choose how they are engaged in the process
- choose whether to participate
- have an equal voice in how partnerships are managed.

Meaningful participation would also mean shifting and sharing power with key populations and their groups and bringing them to the table to design and implement programmes. This involves a considerable shift in the attitude, beliefs, and norms that currently exist among implementers. To ensure that there is meaningful participation of key populations, implementers and policy makers would first have to respect them, have faith in their capacities, and provide them the space and mentoring support to participate equally.

**Community Committees: A Process to Provide Meaningful Participation to Key Populations**

Community committees (CCs) are a model for empowerment that can be adapted across key population programmes. In addition to empowerment, CCs are a tool for effective provision of services. Community committees give power to the community/key populations to participate in governance or management of interventions rather than just providing outreach services or condoms. The ultimate aim is that the interventions will be entirely community led eventually. As such, CCs should be formed in close consultation with key population members, and the structures, roles, and responsibilities of the committees should be developed jointly by the programme and the members. Community committee members (CCMs) should represent the different key population typologies or subpopulation so that each group's interests are represented. Membership should rotate on regular intervals so that the maximum number of key population members have an opportunity to serve.

<sup>125</sup> WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

**Objectives of Community Committees**

- Keep programming relevant to the needs of key population members.
- Maintain community participation in the intervention.
- Sensitize the programme to the community's views and perspectives.
- Strengthen community ownership of the programme.
- Familiarize community members with programme administration, management, and oversight.
- Formalize community participation in programme administration, management, and oversight.

**Example of a Community Advisory Board Committee****Mission**

A community advisory board (CAB) exists to build linkages between key population members and implementing partners and advise and monitor comprehensive service delivery at programme level. Through meaningful and genuine partnerships, the CAB will ensure creation and ownership of a safe environment where sex workers are empowered to lead as role models and make decisions within the programme (e.g., the GALCK Research Advisory Committee among others).

**Roles and Responsibilities**

- Facilitate linkage between the community and implementing partners.
- Advise the program on comprehensive service delivery to address the needs of the community.
- Advise the community on access to comprehensive services provided by the programme.
- Help the community to voice their concerns to the programme and vice versa.
- Support the programme and the community to develop rules of engagement within the programme keeping community interests in mind.
- Conduct community engagement and dialogue to get feedback.

- Follow up action taken on advice/ information and assess how it benefits the community.
- Attend CAB meetings regularly.
- Visit programme sites and interact with the community.
- Understand and review action plan / work plan and support the project in designing the programme of the following year by giving suggestions.
- Participate in project activities, such as trainings, functions, events, etc.
- Bring important issues, problems faced by the community (including rumors), and solutions to the attention of the programme on a routine basis.
- Suggest strategies to address challenges faced by the project, informed by experiences and expertise of CAB members.
- Advise and support (when needed) in advocacy with programme stakeholders.
- Ensure that the community is handled ethically, without stigma and discrimination, with a positive attitude.

### Example of a Crisis Committee

#### Objective

To encourage key populations to report incidents of violence and crisis and ensure effective and efficient support from the programme at the time of crisis.

#### Roles and Responsibilities

- Educate key populations on situation of violence and support offered by the programme.
- Review monthly cases of violence and the support provided by the programme.
- Develop plans to ensure crisis situations can be prevented.
- Get feedback from key populations on the functionality of the crisis management system.
- Advocate with police and other power structures during sensitization meetings.
- Provide support to the crisis management team at the time of crisis by going to the site of crisis or arrest, etc.

Similar committees can be formed to support and manage clinical services or outreach-related services, including condom and lube distribution.

### KP-Led Outreach and Services

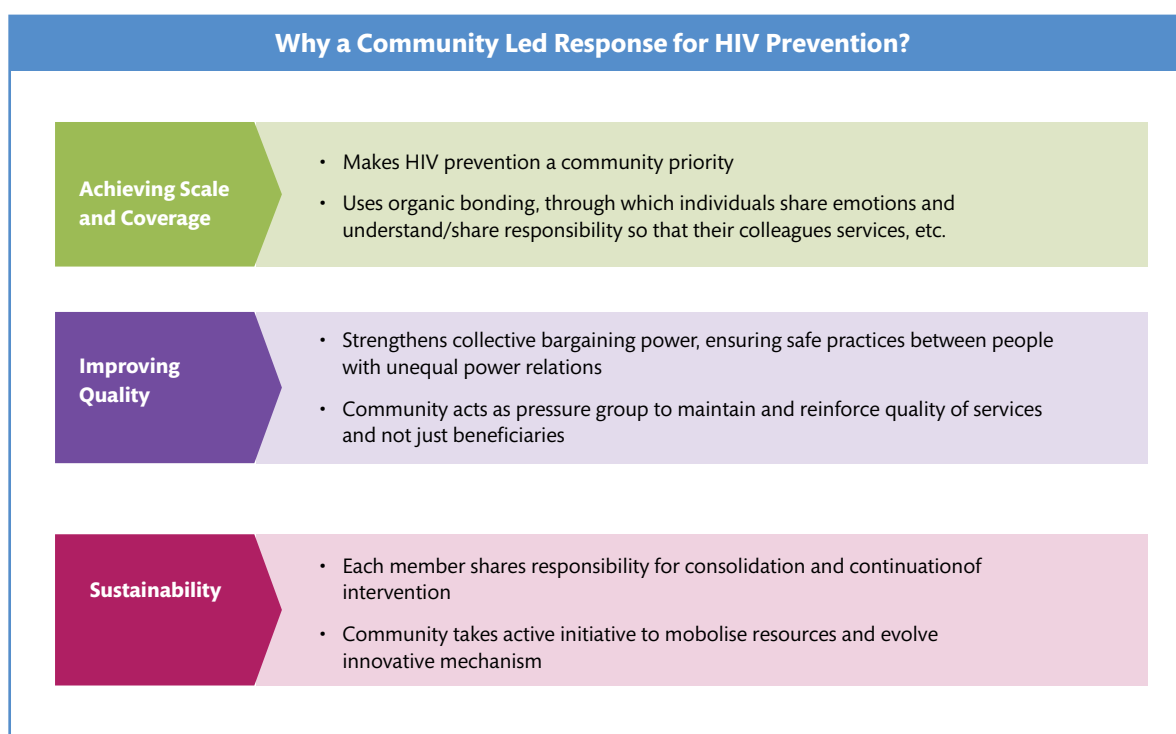
There is a difference between programmes that are **done for** key populations and sex workers and those **led by** key populations. (Figure 14 shows the importance of community leadership in HIV prevention). Programmes that are led by key populations are more likely to align with their needs, perceptions, and experiences. Key-population-led outreach and services emphasize protecting key populations rather than meeting targets, and stimulate a collective identity and solidarity among key populations. This stems from the principle that key populations are natural owners of their programmes.

Key-population-led services and outreach employ sex workers in various positions, not only as peer educators. Processes like micro-planning increase the key population's contribution in planning, implementation, and monitoring of services and outreach. Such processes also involve the key population in problem solving. This process also builds leadership within the key population and strengthens their capacity to take decisions and be accountable.

### 'Safe spaces' or Drop-in Centres (DICs)

From the outset of a programme, safe spaces (also known as drop-in centres) should be established to bring community members together. Safe spaces are rooms rented by the programme and furnished simply that provide community members with a comfortable place to relax, rest, get information, and interact with each other and with the programme. Evidence shows that DICs build solidarity and collective identity, which is very important for community empowerment. The role of drop-in centres is critical given the fact that male and female sex workers/MSM/TG/PWID, especially those who operate from streets, do not have a place where they can safely rest, wash, or meet. Given the extreme and rampant human rights violations of key populations, safe spaces are often the only places key population members can access health care, legal counselling, and other HIV-prevention services.

FIGURE 14: Importance of Community-Led HIV Prevention Response



**Safe spaces are multi-functional;** they may also serve as

- a place where community members may **discuss programmes** with programme managers to improve services
- a place to **provide information on events and activities** relevant to the community (not just program-related information)
- a venue for **psychosocial services and support**, based on community demand
- a **distribution point for condoms** and lubricant
- a place to **strengthen community empowerment** by discussing discrimination and stigma against the community and planning a response
- a place for community outreach workers to **review their work** and plan outreach
- a place for **community trainings** of community outreach workers or of other sex workers (e.g., in violence response, power analysis)

Safe spaces may be located near programme-operated STI clinics, or even in the same building. There are practical advantages to co-locating safe spaces with clinics, such as the convenience of dealing with just one landlord and the closer links between community activities and programme services. Nevertheless, care should be taken to ensure that safe spaces remain a distinct community area. It is often important to separate an implementing organisation's office from the safe space and ensure that community leaders have clear responsibility for managing activities at the safe space.

**Considerations in Starting a DIC**

- Determination of leadership roles and responsibilities in running the center.
- Creation of DIC committees comprising key population representation which will oversee aspects of running the DIC.
- The DIC may or may not offer clinical services, however if there is adequate space, consideration should be given to the provision of clinical services.
- All DICs should adequately stock condoms and other prevention commodities.

**Developing and Strengthening Key Populations or Community-Based Groups or Collectives**

Implementers of HIV programmes with key populations can play a facilitative role in the process of developing groups and collectives by providing space, capacity building, advocacy to remove barriers, and helping them network with other groups. Community-led organisations and networks for key population subpopulations exist in Kenya and can assist this process in places where key populations are not organized. The national networks of key populations (KESWA, KENPUD, GALCK) should also facilitate this process in various counties so that ownership rests with the key populations.

These community-based groups or collectives should follow principles of democracy, equality, transparency, and accountability. Formation of a group or collective will help key populations organize, jointly decide priorities for the whole group, and develop mechanisms for collective and democratic decision making. These groups can also be formalized and registered as community-based organisations (CBOs) and NGOs, and can be strengthened to receive funds and implement programmes. The groups can also decide not to implement, and instead take up an advocacy agenda for the key populations.

**Bringing Key Populations Together<sup>126</sup>**

- Organise group activities at safe spaces based on the interests of the group members.
- Plan activities for special occasions, such as the International Day to End Violence against Sex Workers (17 December) or World AIDS Day, Women's Day, IDAHO, Trans Remembrance Day
- Invite human rights activists or community outreach workers from neighboring areas to speak at a gathering of local key populations.

Forming any collective is challenging, but maintaining and strengthening it is even more difficult. Key population networks face various challenges, including funding, addressing complex community needs, and reaching out to their constituency in a meaningful way. A strong community-led organisation is characterized by vibrant membership, increasing financial independence, greater political power, and broad social engagement.

**Strengthening Management and Organisational Capacity<sup>127</sup>**

- Create a fair and transparent method for making decisions within the organisation.
- Ensure that the process for carrying out and managing activities is participatory, transparent, and has accountability.
- Establish a transparent operational system for managing human and financial resources.
- Key populations should be in control of the planning, implementation, and monitoring of the collective and its activities, including identifying indicators for monitoring.
- Support the growth of group membership and advancing of the group's goals and objectives.
- Encourage cooperation and learning from other key-population-led organisations and networks nationally and internationally.

126 WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

127 WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

To help achieve sustainability, it is important to invest time and resources in building leadership among key populations through their involvement in trainings, conferences, project design, implementation, evaluation, research, and fundraising activities, and through their participation in the wider key population rights movement. It is also essential to develop the organisational skills and capabilities of the collective as a whole. This will involve enhancing business and management skills among group members, strengthening leadership and management, and developing resource mobilization activities. Sustainability will also be achieved if key population led organisations establish and implement sound human resources management systems, financial systems, and procurement and administrative systems. Developing a wider base of skills and leadership within the collective and linking with other organisations can help ensure the sustainability of a key population organisation in the face of changing donor funding or changing leadership in other governmental or non-governmental organisations. To sustain themselves, key population movements should operate in solidarity with other social movements, particularly those that also advocate for human rights.

## 2.10.5 Violence Prevention and Response

A modelling exercise conducted to measure the impact of reducing violence against female sex workers on HIV epidemics in Ukraine and Kenya found an approximately 25% reduction in HIV infections among FSWs when physical and sexual violence were reduced, and the cumulative infections averted were 21,200 and 4,700 in Kenya and Ukraine respectively.<sup>128</sup> Beattie et al. found that a structural approach to addressing violence can be effectively delivered at scale. Addressing violence against sex workers was found to be important for the success of HIV prevention programmes and protecting their basic human rights.<sup>129</sup> Sushena Reza-Paul and her colleagues found that violence by police and anti-social elements, which was

initially most common in the project, decreased substantially after a safe space was established for sex workers to meet and crisis management and advocacy were initiated with stakeholders.<sup>130</sup>

There is growing recognition that HIV-prevention policies and programmes focusing on key populations must incorporate violence prevention and response strategies. The key strategies include group discussion, affirming key populations' identity and rights, and participatory documentation of threats and advocacy for an enabling environment.

### Empowerment of key populations

Key populations can be empowered through group sessions in which they critically reflect on their rights, violence that they experience, and the root causes of such violence. These sessions, which take place in drop-in centres or the hot spots, can be led by trained peers and outreach workers. Building key populations' knowledge on their rights and violence and building their confidence to claim their rights will encourage key populations to report and challenge violence. The sessions should also include developing skills to identify situations of violence and deal with violent people and circumstances. These group discussions also build solidarity among key populations to challenge violence and seek justice. Organisations supporting human rights can be involved in training the peers or outreach workers of the project who then can train the sex workers in their hot spots.

### Raise Awareness on Rights

Another step to violence prevention is to ensure that the key populations value and accept themselves and their work or sexual orientation, and that they know their rights as humans and citizens of Kenya. This has been explained in the section on community empowerment

### Mapping Stakeholders and Advocacy

It is important to sit with key populations and map the perpetrators of violence and influencers who can change the situation. It is also pertinent to rank the perpetrators to understand which perpetrators to prioritize for advocacy. Advocacy with power structures, stakeholders, and law enforcement

<sup>128</sup> Decker M et al. Estimating the impact of reducing violence against female sex workers on HIV epidemics in Kenya and Ukraine: a policy modeling exercise. *American Journal of Reproductive Immunology*. 2013;69 Suppl 1:122-32. doi: 10.1111/aji.12063

<sup>129</sup> Beattie T et al. Violence against female sex workers in Karnataka State, South India: impact on health and reduction in violence following an intervention. *BMC Public Health*. 2010;10:476. doi:10.1186/1471-2458-10-476. <http://www.biomedcentral.com/content/pdf/1471-2458-10-476.pdf>

<sup>130</sup> Reza-Paul S et al. Sex worker-led structural intervention in India: a case study on addressing violence in HIV prevention among Ashodaya Samithi collective in Mysore. *Indian Journal of Medical Research*. 2012;135(1): 98-106. doi: 10.4103/0971-5916.93431. <http://icmr.nic.in/ijmr/2012/january/1216.pdf>

agencies is a key strategy for violence prevention and mitigation. Meetings can be organized at clubs, bars, drug dens, and sex dens to sensitize owners and managers about the relationship between violence and HIV risk, and to obtain their assurance that violence against key populations will not be committed by them or by their customers.

Advocacy with stakeholders to support the campaign to stop violence against key populations can contribute to preventing or reducing violence against key populations. These stakeholders can include media, religious leaders, civil society, elected representatives, and county officials. Advocacy may include change in laws and policies that criminalize key populations or that are used to harass and abuse key populations, or change in law-enforcement practices that harass or abuse key populations and deny them their human rights, or even countering stigma and discrimination against key populations.

#### Advocacy and sensitization activities may include

- public campaigns
- sensitization workshops
- highlighting the issue of violence against key populations on specific international and national days and in campaigns
- disseminating print and other multimedia materials
- working with journalists and other members of the media to promote positive stories
- building partnerships and networks with organisations that work on human rights and HIV, for joint advocacy efforts
- supporting collective action by key populations to demand redress for violence faced by their community members

#### Promoting the Safety and Security of Key Populations

Strategies to promote the safety and security of key populations in their workplaces and communities may be formal or informal. The following should be considered:

- **Maintaining and sharing lists or reports of aggressors** or incidents of violence against key populations. The reports are compiled and distributed to key populations through monthly

bulletins, SMS, or e-mails so that they know to avoid potentially dangerous individuals.

- **Promoting workplace/ drug-place security** by negotiating with owners and managers of sex establishments to protect sex workers from perpetrators of violence.
- **Disseminating information or tips about safety to sex workers** through leaflets and SMS, like asking key populations to carry mobile phones, inform friends before they go with clients/partners, keep numbers to call in case they are in danger.
- **Creating safe spaces (drop-in centres)** or shelters that allow key populations to come together and discuss common issues and problems they face, including violence, and develop and exchange solutions.
- **Integrating violence prevention in HIV-prevention counselling interventions with key populations.**
- **Setting up a 24-hour crisis-support telephone line** that the key populations can call at the time of violence/crisis and seek support. The line should be managed by key population members and a mechanism should be worked out to ensure that support reaches within 30 minutes.

#### Providing Health and Legal Services to Key Populations Who Experience Violence

Key populations who experience physical, sexual, and psychological violence may need medical care in both the short and long term. In Kenya there are gender-based violence centers with hospitals and it is important for the interventions to establish formal linkages with such centers. It may be useful to consider integrating services for those who experience violence into the broader set of HIV prevention, treatment, and care and other health services for key populations. It is important that the key populations who experience violence are referred to a place that can provide post-exposure prophylaxis, emergency contraception, general examination, and psychological support. WHO has developed clinical and policy guidelines for the health sector response to violence.<sup>131</sup>

<sup>131</sup> WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

### Topics for training health-care providers in addressing violence against key populations

- Basic information about violence, including laws and policies against violence with a focus on key populations.
- Identifying those who may be experiencing violence based on physical or psychosocial symptoms (e.g., depression, anxiety, post-traumatic stress disorder, suicidality or self-harm, substance use, injuries).
- When and how to inquire about violence.
- Collecting forensic evidence for investigating sexual violence.
- Providing clinical and psychological care and treatment as per WHO recommendations.
- Where to refer for support services in the community.
- Providing non-judgmental care that does not stigmatize those who experience violence.
- Implications of mandatory reporting of violence (not recommended in the WHO guidelines).
- Although not in the WHO guidelines on health-sector response to violence, in the context of key populations, training may also include
  - ▶ human rights of key populations
  - ▶ laws and policies pertaining to sex work / same-sex relationships/ drug use make key populations vulnerable to violence
  - ▶ violence faced by key populations in health care settings and obligations of health care providers not to discriminate, stigmatize, or perpetrate violence

### Legal Support

This may require engaging or linking with lawyers or trained paralegals (e.g., key populations trained as paralegals) who can help negotiate with legal and judicial authorities about incidents of violence, advocate on behalf of key populations, and support training and sensitization of key populations and others on laws related to sex work.

#### Roles of Paralegals

- Educate the key populations about their rights.
- Be available on spot and report whenever the key populations experience violence.
- Accompany victims of violence for medical support.
- Support victims of violence to register a complaint in a police station.
- Provide avenue for alternative dispute resolution (ADR).
- Link key populations who experience violence to medical, legal, or psychosocial services.

### What are the potential resources needed for providing legal, psychosocial, and other support services?<sup>132</sup>

#### Resource people

- Designated and trained key populations to operate the helplines or hotlines
- Community outreach workers
- Trained peer and/or professional counsellors for psychological support
- Lawyers or paralegals (could be trained sex workers) who can provide legal support

#### Materials and venue

- Access to a venue
- Mobile phones and time credit
- Hotlines
- Internet access
- Print materials to advertise services
- Data collection and reporting forms
- A space to operate hotlines, conduct trainings and meetings
- Safe space (drop-in centre) or shelter

<sup>132</sup> WHO. 2013. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1)

### Costs

- Remuneration for staff (including lawyers if not pro bono)
- Start-up and maintenance costs of sex workers to use mobile phones, hotlines
- Advertising the services
- Transport costs
- Training

### Fostering Police Accountability

Working with the police and law enforcement has been a key element of efforts to reduce violence against key populations. Activities may include

- **Sensitization workshops with the police and law enforcement** that raise their awareness of laws related to key populations and human rights. These workshops also build relationships between key populations and law enforcement in order to minimize police harassment and violence. In some settings, such workshops have been led by key populations, in other places they have involved lawyers, and in some settings sex workers, police and NGOs have jointly conducted trainings (e.g., Keeping Alive Societies' Hope [KASH] in Kenya).
- **Regular advocacy meetings** with police as well as with high-level law enforcement authorities to reduce police harassment of sex workers and community outreach workers (e.g., getting letters of support from the police that are carried by the outreach workers) and to ensure the commitment of frontline officers to the workshops.

Reflections on police training from organisations involved in these efforts suggest that police training and working with the police may provoke a backlash against key populations and hence this needs to be monitored. It is important to gain support at senior levels in the police hierarchy in order to get and sustain support from police lower down and hold them accountable for their actions. Building relationships with police and educating them about sex worker rights has to be a continual process.

### Developing Evidence and Documentation

Documenting and generating evidence of violence against key populations is essential for advocacy with police, local authorities, media, and national policy makers. Note that there are ethical and safety concerns around collecting research data on violence against key populations that should be carefully considered.

### Documenting Violence Faced by Key Populations and Defending Their Human Rights

Activities could include

- gathering data or information on different forms of violence faced by KPs
- documenting abuses and incidents of violence faced by KPs
- facilitating their access to services: justice through legal services, etc.
- ▶ Violence prevention and response are essential components of HIV-prevention programmes.
- ▶ Violence prevention and response programmes need to be comprehensive and should protect key populations' right to privacy, justice, and equality.
- ▶ Incidents of violence need to be monitored and reported, and legal redress mechanisms established to provide justice to key populations.
- ▶ Law enforcement officials and health and social care providers need to be trained to recognize and uphold the human rights of key populations, and held accountable if they violate the rights of key populations, including the perpetration of violence.
- ▶ Support services need to be provided to key populations who experience violence.

## Key Resources

### Peer Education:

1. NASCOP. Draft. *My Life, My Power: Developing Agency and Power for Sustainable Safer Sexual Behavior (3SB): A Training Curriculum for Peer Educators on HIV Prevention and Risk Reduction among MSM in Kenya*. Nairobi: NASCOP.
2. NASCOP. Draft. National Peer Educators Reference Manual for Sex Workers. Nairobi: NASCOP.
3. NASCOP. 2010. *Standards for Peer-Education and Outreach Programs for Sex Workers*. Nairobi: NASCOP. [http://nascop.or.ke/library/Marps/Standards\\_for\\_Peer\\_Education\\_and\\_Outreach\\_Program\\_for\\_Sex\\_Workers.pdf](http://nascop.or.ke/library/Marps/Standards_for_Peer_Education_and_Outreach_Program_for_Sex_Workers.pdf)

### Biomedical Interventions

- WHO. 2014. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. Geneva: WHO. [http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)

### PWID HIV Programming

- NASCOP. 2013. *Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use*. Nairobi: NASCOP. <http://nascop.or.ke/library/Marps/Final-MOH-Comprehensive%20Management%20of%20the%20Health%20Risks&Consequences%20of%20Drug%20Use.pdf>
- NASCOP. 2013. *Standard Operating Procedures (SOP) for Needle and Syringe Exchange Programmes (NSEP) for People Who Inject Drugs (PWID)*. Nairobi: NASCOP. <http://nascop.or.ke/library/Marps/NSEP%20BOOK-SOP-NEEDLE%20&%20SYRINGE%20EXCHANGE%20PROGRAM.pdf>
- NASCOP. 2013. *Standard Operating Procedures for Medically Assisted Therapy for People Who Use Drugs (PWUD)*. Nairobi: NASCOP. <http://nascop.or.ke/library/Marps/MAT%20Book-SOP-Medical%20Assisted%20Therapy.pdf>
- International HIV/AIDS Alliance. 2012. *Reaching Drug Users with Outreach Services; A Toolkit for Outreach Services*. [http://www.aidsalliance.org/assets/000/000/380/90629-Reaching-drug-users-A-toolkit-for-outreach-services\\_original.pdf?1405520658](http://www.aidsalliance.org/assets/000/000/380/90629-Reaching-drug-users-A-toolkit-for-outreach-services_original.pdf?1405520658)
- WHO. 2004. *Evidence for Action: Effectiveness of Community-Based Outreach in Preventing HIV/AIDS among Injecting Drug Users*. [www.who.int/hiv/en](http://www.who.int/hiv/en)
- Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute. 2008. *“Nothing about Us without Us”: Greater, Meaningful Involvement of People Who Use Illegal Drugs: a Public Health, Ethical, and Human Rights Imperative*. [www.aidsalliance.org/publicationsdetails.aspx?id=310](http://www.aidsalliance.org/publicationsdetails.aspx?id=310)
- National Institute on Drug Abuse. 2000. *The NIDA Community-Based Outreach Model: a Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users*. Bethesda, MD, USA: National Institutes of Health. Available at: [archives.drugabuse.gov/CBOM/](http://archives.drugabuse.gov/CBOM/)
- Broadhead R. N.d. *Peer-Driven Intervention*. Storrs, Connecticut: University of Connecticut, Center for Health Intervention and Prevention. [www.chip.uconn.edu/chipweb/pdfs/PDI%20Summary.pdf](http://www.chip.uconn.edu/chipweb/pdfs/PDI%20Summary.pdf)

### Mental Health

- For comprehensive details on mental health interventions in non-specialized health settings please refer to the World Health Organization’s *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*; Version 1.0 [http://whqlibdoc.who.int/publications/2010/9789241548069\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf)

# Programme Management

## CONTENTS

*Chapter 3 presents the overarching programme coordination and management structures of key population programming from grassroots through to national level.*

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- 3.2 Programme Science
- 3.3 Planning for Key Population Programme Implementation
- 3.4 The National Key Population Steering Committee
- 3.5 The Role of NASCOP
- 3.6 The Role of County Health Management Teams
- 3.7 The Role of Implementing Agencies
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## INTRODUCTION

Effective programme coordination at the national and county levels is critical to monitor and improve the quality of interventions and achieve intended outcomes. The collaborative coordination of the HIV response by NACC and management of implementation by NASCOP and implementing partners ensures that the national key population programme maintains relevance. National-level programme coordination and implementation are comprehensively outlined in the Kenya AIDS Strategic Framework.

## 3.2

### PROGRAMME SCIENCE

The **Programme Science Initiative** is defined as the systematic application of theoretical and empirical scientific knowledge to improve the design, implementation, and evaluation of public health programmes.<sup>133</sup> Programme Science provides a framework that applies science to programming to ensure appropriate focus on correct geographic areas, high-priority groups, right mix of interventions, optimal delivery mechanisms and options, real-time monitoring, and tactical and strategic adaptations.

## 3.3

### PLANNING FOR KEY POPULATION PROGRAMME IMPLEMENTATION

NACC has developed HIV county profiles based on general population statistics whilst NASCOP has developed a key population database which will feed into these county profiles.<sup>134</sup> Mapping and size estimation data (discussed in Chapter 2) at county and at national level should be used to inform the scope and scale of the necessary key population

programming:

- There should be appropriate analysis of entire county mapping data broken down to sub-county, and then the same plotted against the current coverage.
- The data should include all the details and information collected during mapping (e.g., locations of key populations, typology, and numbers/concentrations by region).
- The map should also include information of existing implementing partners and their coverage.

This geographic analysis will reveal gaps in programme coverage. Based on these gaps, implementing partners and interventions can be configured or supplemented as per the criteria below.

#### **Criteria for Planning Key Population Interventions: Interventions will be allocated based on the following criteria:**

- Locations where there are no interventions
- Large pockets of key populations
- Smaller pockets of key populations
- Locations where HIV prevalence rate is higher than other districts
- Locations where sizeable number of key populations exist with some interventions but not covering 100% of key populations
- Locations where the outreach of existing interventions covers less than 80% of the key population
- To achieve economic efficiency
- To achieve 80% coverage of Kenya's key populations

**When planning and mobilizing resources for key population programming, implementing partners should ensure that their project proposals specifically disaggregate by subpopulation, the direct beneficiaries they intend to reach.**

<sup>133</sup> Blanchard JF and Aral SO. Program Science: an initiative to improve the planning, implementation and evaluation of HIV/sexually transmitted infection prevention programmes. *Sex Transm Infect.* 2011;87: 2-3. doi: 10.1136/sti.2010.047555 [http://umanitoba.ca/faculties/medicine/units/community\\_health\\_sciences/departamental\\_units/cgph/media/Sex\\_Transm\\_Infect-2011-Blanchard-2-3.pdf](http://umanitoba.ca/faculties/medicine/units/community_health_sciences/departamental_units/cgph/media/Sex_Transm_Infect-2011-Blanchard-2-3.pdf)

<sup>134</sup> NACC and NASCOP. 2012. County HIV Profiles. <http://www.nacc.or.ke/countyprofiles/>

## 2.4

### THE NATIONAL KEY POPULATION STEERING COMMITTEE

The KNASP III identified an enabling policy and legal environment as a facilitating factor in programming for key populations. In order to create this enabling environment and operationalise key population engagement, NACC established a National Steering Committee (NSC) to provide clear policy direction to respond to epidemics.

The NSC and the existing TWG are linked by their complementary mandates and communicate through their respective chairpersons and members who sit in both entities. Programming challenges that can be addressed through policy will be communicated to the NSC by the TWG convener, NASCOP. The NSC will also work with county structures that currently exist or that will be formed to address key population HIV programmes. There is need for coordination among the county governments on KPs. A coordination structure will be developed to outline the linkages and communication between the NSC and County Technical Support Units. This structure will provide direction on policy implementation in the counties, generation of strategic information/evidence at the county level, and reporting and compilation of this information at the national level. The strategic information generated will form part of the county profiles, ensuring that key population issues are included in county development plans.

The NSC will support NACC's traditional role of coordination, policy formulation, and resource mobilisation for target key populations. The targeting of key populations shall not limit implementers from targeting vulnerable populations. As new evidence becomes available, other groups that are currently categorized as vulnerable will be flagged out for upgrading as key populations in KNASP IV document where necessary. These groups may include fishing communities, migrant populations, and long-distance truck drivers.

The NSC's mandate includes the following:

- Spearhead national HIV-response policy formulation, review, and coordination targeting key populations
- Set the Research, Monitoring, and Evaluation agenda for key populations and advise on policy translation of research findings
- Coordinate/harmonize key populations programming nationally to ensure resource allocation is matched with need, both in scope and geographical coverage
- Review service coverage and size estimations
- Identify resource needs and mobilize resources
- Advocate for human rights-based service delivery and engagement of key populations
- Work closely with the TWG to ensure the highest quality standards for KP programming

#### Membership

- Members will be drawn from government ministries, development partners, private sector, civil society organisations and members of the key population community. The NSC will have a maximum of 16 members. Members will be co-opted on the basis of specialized needs/skills.

#### Frequency of Meetings

Meetings shall be held quarterly at the National AIDS Control Offices and shall be chaired by the Director, NACC. Special meetings may be called as need arises.

## 3.5

### THE ROLE OF NASCOP

Anchored within the National Health Sector Strategic Plan, the National AIDS and STI Control Programme bears overall responsibility for implementing/managing key population HIV programmes in the country.

**The Key Population Programme under NASCOP coordinates and monitors the activities of partner agencies implementing**

**programmes to ensure**

- Adequate coverage and saturation of key populations
  - Efforts are not duplicated
  - Interventions provided by implementing partners accomplish the desired strategic goals and objectives of the country, are aligned with national service delivery guidelines, and are within the standards for the minimum quality of interventions
  - The provision of technical support and mentorship to implementing partners
  - Adequate provision of necessary prevention commodities and supplies
- ii. Reporting
  - iii. Maintaining the KP database
  - iv. Innovation
  - g. Quality Assurance (QA) and Quality Improvement (QI)
    - i. Development of quality standards
    - ii. Implementation
    - iii. Conduct QA/QI activities
  - h. Strategic Information (research, evidence, dissemination of findings)
    - i. Development of a research agenda at the county and national level (e.g., KP size estimates)
    - ii. Validation of research findings
    - iii. Clearinghouse for KP research
    - iv. Innovation and best practices—replicate high-impact interventions
  - i. Partnerships, Networking, and Resource Mobilisation
    - i. Contribute towards Global Fund concept development, etc.

NASCOP is supported in its management role by two interlinked structures:

1. **The NASCOP KP Technical Working Group:**  
The TWG's mandate is to provide guidance on the overall programme management for KPs in the thematic areas of
  - a. Policy, Strategy, and Guidelines
    - i. Advocacy
    - ii. Training
  - b. Capacity Building
    - i. Capacity needs assessments (human resource, infrastructure, etc.)
    - ii. Training
    - iii. Institutional strengthening
  - c. Commodity and Supplies Management
    - i. Forecasting and quantification of commodities
    - ii. Logistics management
  - d. Service Delivery
    - i. Service delivery models and packages
    - ii. Standards
    - iii. Innovation
  - e. Coordination and Supervision
    - i. County-specific partners and programmes mapping (scope and coverage, ensures minimum duplication, etc.)
    - ii. Advise development partners on areas of greatest need for social investments.
  - f. Monitoring and Evaluation
    - i. Ongoing validation

It is important to recognize the interrelationships between these thematic areas. Subcommittees will continue to exist as per the three key populations—SW, MSM, and PWID—in addition to the M&E subcommittee. Issue-based *ad hoc* meetings will be convened as need arises.

All new implementing partners and donors and researchers in the field of key population programming should engage NASCOP at the inception of their project design processes to facilitate introduction into the wider TWG forum. This ensures geographical and typological harmonization of implementation efforts and the development of synergies on the ground.

2. **The NASCOP Technical Support Unit (TSU):** This is a national-level technical support structure that is responsible for providing technical support to key population programming at national and county levels. The TSU provides strategic and implementation support at national, county, and sub-county levels to NASCOP, NACC, and key population programme implementers in close collaboration with the County AIDS/STI Coordinator (CASCO).
  - a. TSU Technical Officers (TOs) provide strategic support in five key areas:
    - i. Development of national key population guidelines.
    - ii. Development of national and Learning Site training curricula aligned to the guidelines.
    - iii. Development of national communication materials.
    - iv. Coordination of key population outreach and mobilisation.

- v. Development and maintenance of a key population M&E system.
    - vi. Support the Learning Sites.
  - b. TSU Field Officers (FOs) are responsible for planning and coordinating the implementation of effective HIV-prevention programmes among key populations by local NGOs and CBOs within their regions. The ultimate aim is to ensure that all key population programmes implement interventions based on the national key population guidelines, standards, and protocols. This will be achieved through routine field visits, support and mentorship, and monitoring and evaluation in close collaboration with the CASCO. The FOs will especially focus on strengthening peer education and outreach programmes, which in turn would lead to higher services uptake. Their responsibilities include
    - i. Supporting the establishment and strengthening of key population outreach
    - ii. Ensuring flow of information to the national TWG
    - iii. Supporting networking and collaboration among governmental and non-governmental organisations (implementing partners, CBOs, and FBOs) involved in key population programming
    - iv. Facilitating capacity building activities and training workshops among organisations implementing key population programmes
    - v. Supporting CBOs and implementing partners to monitor and evaluate key population programmes in accordance with an agreed performance measurement framework.
  - c. It is also the responsibility of the Field Officers to
    - i. disseminate information, education and communication materials on advocacy for key population programming;
    - ii. regularly document processes of key population programming activities, highlighting challenges and lessons learned;
    - iii. plan field visits for at-least 12 days per month in key population programme sites in collaboration with implementing partners; and
    - iv. respond to partner requests and general queries on key population programming policy and advocacy issues.
- 3. **County and Key Population Level Community Advisory Boards (CABs):**  
Based on the researcher/community engagement model, community advisory boards are reference groups consisting of KP representatives who meet with programme implementers to relay information between implementers and the community. Community Advisory Boards build and foster partnerships between implementing partners and local KP communities impacted by HIV/AIDS. CAB members represent local KP interest groups and/or individuals at CAB meetings. Members are responsible for reporting information discussed at CAB meetings to their respective organisations/communities, to increase public knowledge of the project/programme.
  - a. County- and Programme-Level CABs
    - i. At county level, CABs may include KPs and relatives of KPs (the latter including aunts, uncles, spouses, parents, brothers, and sisters)
    - ii. At programme level, they will be comprised of KPs
  - b. CAB Mission and Goals
    - i. Every CAB should have a clearly defined mission statement, which should be developed early in the life cycle of the CAB, in collaboration between CAB members and programme staff.
    - ii. It is advisable that CABs establish goals for their work that allow for further detailing of how the CAB will achieve its mission.
  - c. CAB Membership
    - i. A CAB should have diverse representation, bringing together members with different profiles, experiences, and expertise.
    - ii. An implementing partner should make sure that relevant populations are well represented in the CAB.
  - d. Implementing Partner Responsibility

- i. Every implementing partner should designate liaison staff for its CAB, usually called a CLO (Community Liaison Officer), with adequate capacity to provide technical assistance to the CAB at every stage of its growth.
- ii. The CAB should have regular interaction with programme staff. It is recommended that the programme manager /supervisor meet with the CAB on a regular basis.
- iii. The implementing partner should provide adequate resources for the CAB to function effectively—negotiated CAB-related expenses, such as meeting space, supplies, transport, and trainings, should be incorporated into the programme budget.
- e. CAB Operations
  - i. CABs should develop a charter to formalize their operations and structure in a consensual document.
  - ii. Appropriate roles should be assigned to CAB members to form a governing structure for the CAB.
  - iii. It is recommended that CABs meet monthly during their first year of operation and at least quarterly after the first year.
  - iv. CLOs should work with the CAB to develop a strategic set of activities or action plan that accurately reflects the prevention agenda of the programme and surrounding community concerns.
- f. CAB Member Training
  - i. An initial training cycle should be offered to all CAB members, including orientation about the programme and the role of the CAB.
  - ii. An assessment of training needs and refresher training should be offered to CABs periodically, or whenever significant new information that may affect the programme becomes available.

## 3.6

### THE ROLE OF COUNTY HEALTH MANAGEMENT TEAMS

Building on existing management structures within national HIV programming, the KP Division under NASCOP will engage County Health Management Teams to support the implementing partners and CBOs in coordination of activities, procurement, data management issues, and challenges that may arise.

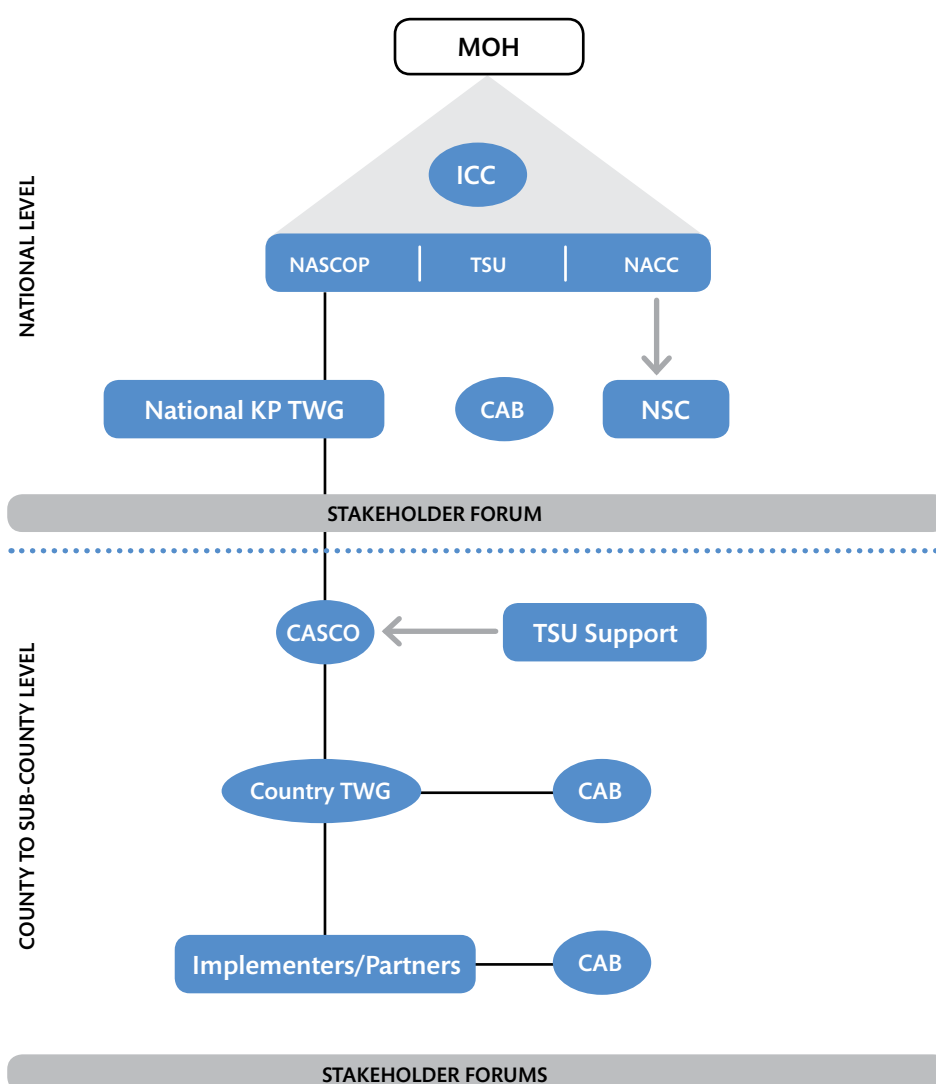
At County level, overall responsibility for the implementation of key population programming will be the County Health Management Team under the leadership of the Health Services Department County Health Executive and comprised of the following offices:

- County Health Executive
- Chief Health Executive
- County Director of Health
- CASCO
- TSU representatives
- County-level taskforce for KP/TWG, which is comprised of the following:
  - ▶ KPs
  - ▶ Law enforcement agents
  - ▶ County commissioner or agent
  - ▶ Media – health reporters
  - ▶ KEMSA (plays a cross-cutting role from county to national level)
- The national-level team, which is comprised of the following:
  - ▶ National TWG, which includes the County Health Management Team, NACC & NASCOP (TWG chair)
  - ▶ National Steering Committee
  - ▶ KEMSA

FIGURE 15: **Lines of Reporting**



FIGURE 16: **Implementation Communication Flow**



# 3.7

## THE ROLE OF IMPLEMENTING AGENCIES

Agencies (NGOs/CBOs) implement interventions in their respective programme locations. The implementing agencies develop a programme proposal and work plan that guides the implementation of the intervention. The role of the agencies is to ensure

- Key populations in their intervention sites receive services that are in line with /address the national guidelines, as agreed in the contract/ proposal with development partners.
- The agencies are responsible for providing the essential combination prevention package discussed in Chapter 2 and, if resources permit, additional extended biomedical, behavioural, and structural components as agreed in the contract and as stipulated in the national guidelines in the prescribed location with key populations.
- The agencies will report on indicators set by NASCOP on a quarterly basis within 10 days of quarter getting over.
- The agencies are responsible for
  - ▶ local problem solving, for which they may seek advice from the technical support unit in collaboration with the CASCO and NASCOP;
  - ▶ recruitment of the local team;
  - ▶ setting up monitoring and evaluation systems as guided by NASCOP;
  - ▶ reporting back to NASCOP using the standardized key population programme M&E system and structures.

### The Implementation Team at Implementing Partner Level

A multi-component HIV intervention for key populations requires team members with a variety of skills. The composition of the implementation team will depend on the services provided, how

the services are delivered, and the size of the key populations and the geographic area being covered. The team will include both community and non-community members.

### Optimum service provision ratios in programming for female sex workers, men who have sex with men, and transgender women

- One peer educator for every 60 key population service users, depending on the population density within the area of coverage
- One outreach worker for every four peer educators, which translates into one outreach worker for every 240 FSW and MSM/ MSW service users

### Optimum service provision ratios in programming for people who inject drugs

- One peer educator for every 40 people who inject drugs
- One outreach worker for four peer educators, which translates into one outreach worker for every 160 PWID service users

### Example of a Core Implementation

**Team (Figure 17):** This is intended to provide services to 1000 FSW/MSM/TG key population service users:

1. Programme Coordinator (1)
2. M&E officer (1)
3. Outreach Worker (4)
4. Peer Educators (17)
5. Biomedical team consisting of a doctor, a nurse, and a counsellor would be based on the programme design and requirements.
6. The team may hire other staff, like accountant, cleaner, DIC coordinator, etc., for programme support.

### Project Management

- The **Programme Coordinator** will be responsible for overall implementation of the programme.
- The **Monitoring Officer** will be responsible for generating reports and monitoring quality of reporting.

- **Doctors and Nurses** may be included to provide biomedical components of the programme.
- **Counsellors** will support the behaviour change process and can be placed in clinic or the DIC.
- **Outreach Workers and Peer Educators** will be responsible for the behavioural and structural programme components. The current implementation context is characterised by various partners paying outreach workers variable fees. This has tended to result in a high turnover of outreach workers seeking engagement with those implementing partners offering the highest wages. This turnover has adversely affected the quality of work. In order to address this challenge, NASCOP in collaboration with the KP TWG recommends that outreach workers who manage peer educators should receive a monthly remuneration of between Kenya Shillings 10,000 to 12,000. Similarly the remuneration range for peer educators has been set between 3,500 and 4,500 per month. Incentivised remuneration for peer educators is not encouraged.
- **In PWID programmes**, salaries and remuneration for outreach workers and peer educators: Remuneration package for outreach workers should be set between Ksh 10,000 and 20,000 and for pathfinders to be Ksh 3,500 and 4,500 per month.

### Recruitment of Project Staff

Based on criteria of peer educators and outreach workers discussed in Chapter 2, the implementing agency should plan its own selection methods (e.g., group discussion, written examination, and interview). When hiring new staff, it is essential to consider the attitudes, knowledge, and experiences that will enable them to work successfully in the programme. They should be sensitive to issues of gender, sex, and sexuality and be able to deliver services in a non-judgmental manner which does not make key population service users feel uncomfortable or stigmatized. Sensitivity and understanding of the challenges of poverty, discrimination, and violence faced by key populations are also essential.

Staff members should include professional

personnel as well as community members, and professional personnel should include women and men to ensure gender balance.

### Peer Guides

Any intervention for key populations requires the active involvement of members of the community from the outset. Peer guides selected from the community can help the field team gain access to the key population, identify locations, help to estimate the size of the group, collect data for the initial survey, and assist the investigator throughout the assessment. This also establishes a norm for the involvement of the community in making decisions for all activities concerning them. Peer guides who are absorbed into programme activities as peer educators / outreach workers once the programme is initiated give outreach a familiar face, which helps to increase uptake of services.

#### Criteria for Peer Guide Selection:

Implementing agencies should select peer guides who are

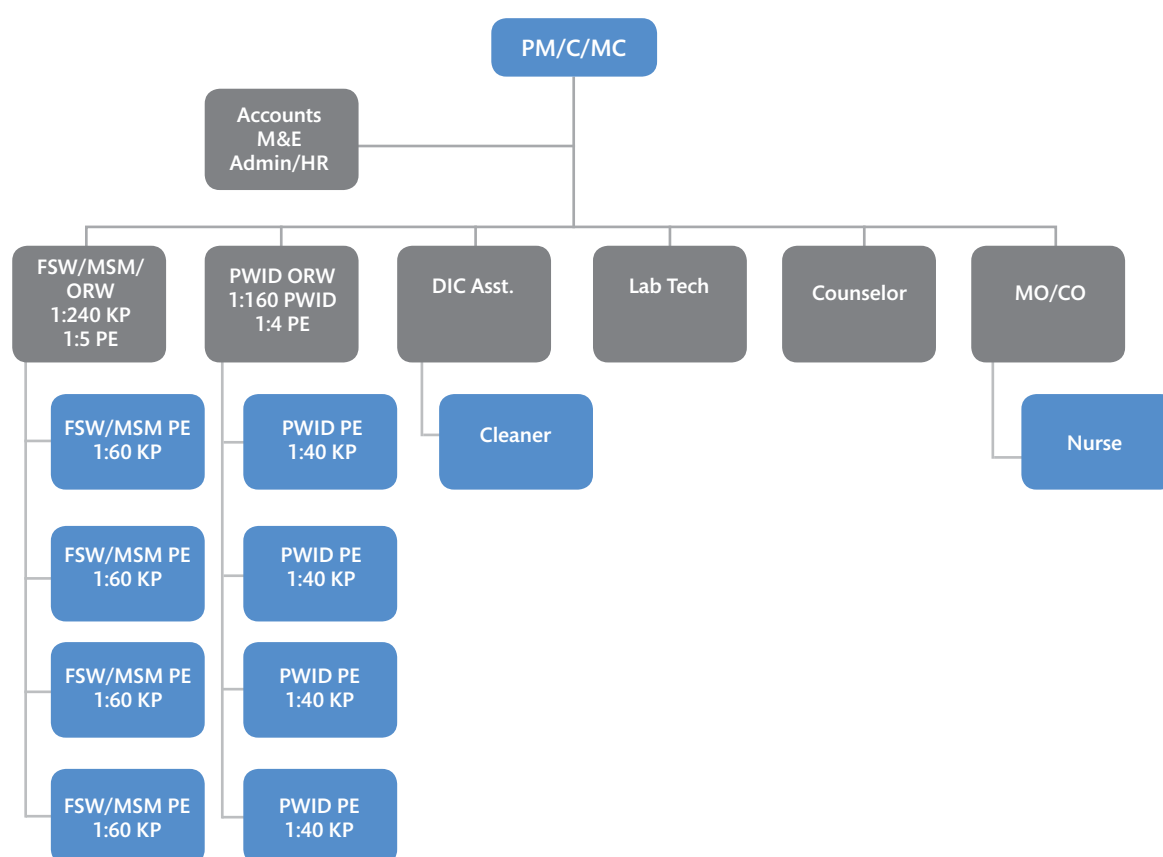
- Available for the programme in terms of time
- Keen to work in the programme
- Representative of and accepted by the community
- Representative of multiple 'social networks' from different locations/sites
- Knowledgeable about the local context and setting

A capacity building training for peer guides should focus on HIV, the intervention programmes, and on the process of site validation.

### Establishing Roles and Responsibilities

To minimize confusion and ensure smooth programme implementation, it is important to outline clear yet flexible staff roles and responsibilities. Flexibility ensures that staff can fill multiple roles if needed and provides the opportunity for capacity building. Programme managers should clearly communicate changing roles, responsibilities, and reporting lines so that staff are aware of what they are expected to do each time new duties are assigned and who will hold them accountable. Annex 3.1 provides a detailed description of illustrative roles and responsibilities for project staff. Programme staff structure is diagrammed in Figure 17.

FIGURE 17: **Organogram for a Key Population Programme**



### Capacity-Building Plans

Capacity building will be provided to the following:

- Contact persons
- Peer educators
- Peer supervisors
- Non-peer staff
- Outreach workers
- Field officers
- Programme coordinators
- M&E officers
- NGO head
- Counsellors
- Doctors

- Paramedical staff
- Paralegal personnel

### Resources

- Operational guidelines for FSWs/MSM/MSWs/TG
- Participatory enumeration and assessment
- Training for peer educators in community-led programming
- Training on community-led monitoring systems
- Training on community-led advocacy
- These resources are available and can be provided during the capacity building process.

Training modules will be developed for all the planned trainings. Each module will have training/facilitator's manuals and a participant's handbook that the participants can carry with them and refer

to later on. These manuals and resource materials will be standard across the country. The trainers using these manuals will be trained to adapt to the local realities in their county/sub-county.

Strengthening the capacity of PWID programme staff will include supporting peer educators and outreach workers to participate in conferences and workshops and help them to prepare presentations, abstracts, and key messages and look for funding to participate in these events.

## 3.8

### MONITORING AND EVALUATION

Monitoring and evaluation is a critical part of programme implementation because it allows programme staff to assess progress, refine activities, and evaluate outcomes and impact. The specific strategy for ongoing M&E should be developed during programme planning and should incorporate opportunities for participation and input from community members.

M&E should answer the following questions:

- Are we following the programme plan?
- Are we on schedule?
- Does the programme have enough coverage?
- What changes are happening?
- How much change is happening?
- How much change is caused by our activities?
- Should we modify our programme in any respect?

Biological and behavioural baseline data should be collected at the beginning of the programme to facilitate the future evaluation of the effectiveness of interventions. Programme staff and key population members should be involved in developing the programme 'logic model' to provide a sense of ownership over the programme. Such involvement builds the capacity of staff and community with first-hand knowledge about the

needs of the community and progress, obstacles, strengths, and weaknesses, of the programme.

### 3.8.1 Programme Data for Key Population M&E

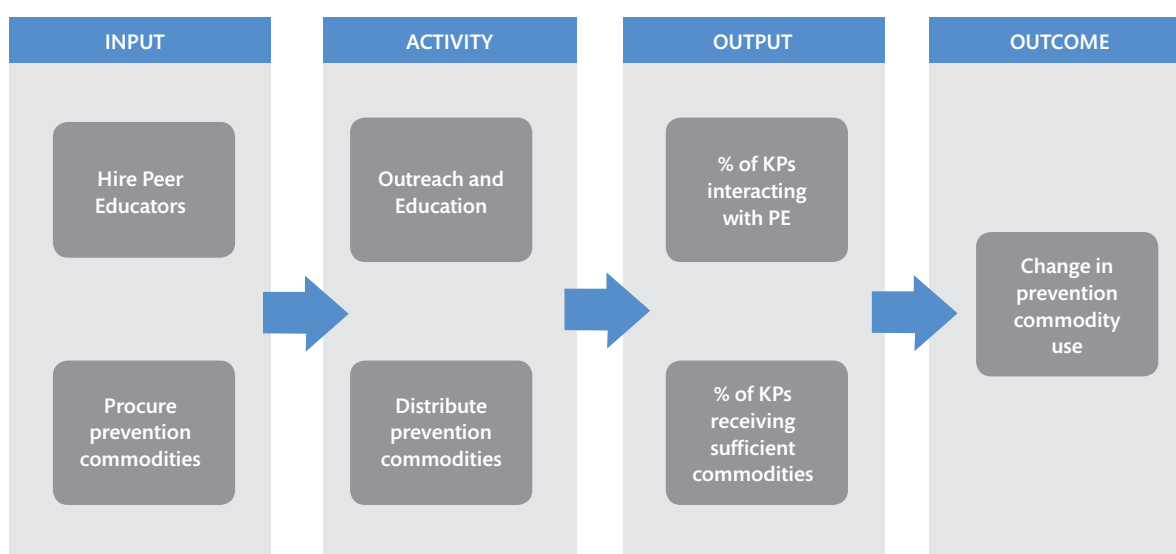
#### The Use of Programme Data

- Data collected routinely to manage and monitor implementation of programmes
- Organised and shared between key functionaries within the programme to optimize their performance
- Systematically reported by implementing organisations to funders and other responsible bodies

#### Types of Programme Data (Figure 18)

- Inputs
  - ▶ Personnel and staffing patterns
  - ▶ Service points and resources
  - ▶ Preventive commodities (e.g., condoms, needle/syringe)
- Activities
  - ▶ Defined interactions with key populations
  - ▶ Service delivery activities (e.g., clinics held)
  - ▶ Advocacy activities
- Outputs
  - ▶ Specific measurable achievements related to activities (amount, quality, volume of use by key populations)
- Outcomes
  - ▶ Measurable changes in key population members as a result of programme activities (behavioural, skills, health status, etc.)

FIGURE 18: Illustrative Example of Implementation Data



### Advantages of Systematic Use of Programme Data for M&E

The systematic use of programme data has distinct advantages:

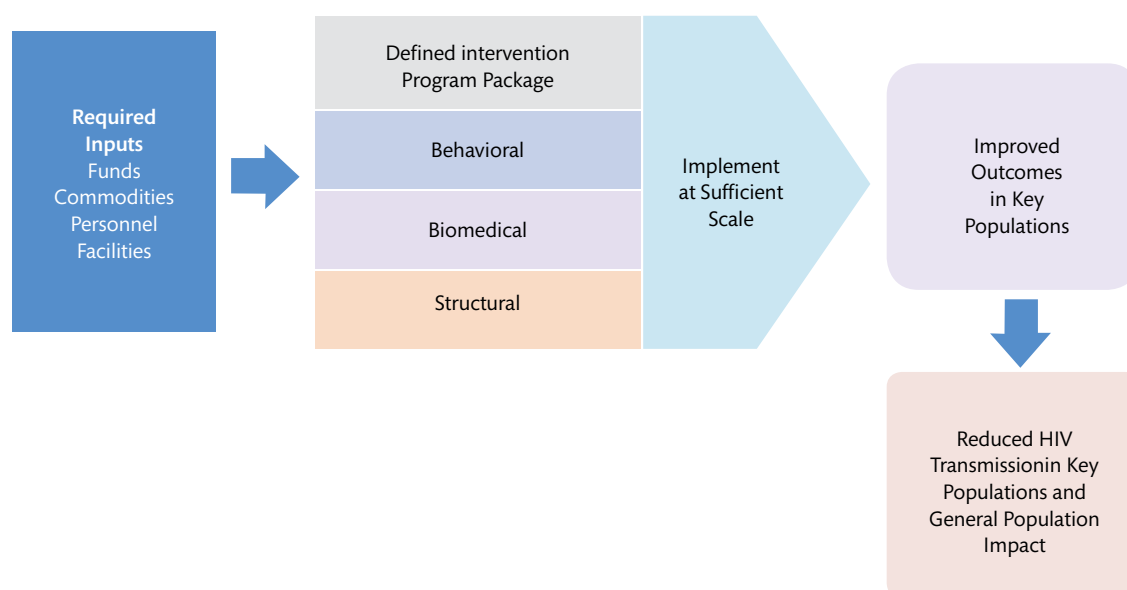
- Investment in programme monitoring methods and tools will strengthen implementation and empower implementing organisations.
  - ▶ Continuous identification of opportunity gaps
- Provides coherence and accountability from the field to central level (sub-national and national)
  - ▶ Responsible national and sub-national agencies can assess and adjust implementation platforms based on concurrent monitoring

### Key Issues in the Use of Programme Data

Using programme data requires critical consideration of the following issues:

- The need for denominators (i.e., key population size) at all levels to calculate coverage
- Common programme intervention package and common indicators
- Harmony across funders and sub-national domains
- Capacity and support at the implementation level
- A system for routinely gathering, aggregating, and analysing programme data at all levels

Figure 19 illustrates a simplified M&E framework for key population programming.

FIGURE 19: **Simplified M&E Framework for Key Populations**

### 3.8.2 Technical Infrastructure

- Good monitoring and evaluation require suitable technical support at the national and sub-national levels to set standards, monitor implementation and collate and report data.
- Standards for implementing organisations should include a consistent monitoring process along with tools to measure and report.
- Supportive supervision is required, particularly at the level of implementation.

#### Justification for a Computerised Management Information System (CMIS)

In alignment with the national shift in programming to scale for key populations and the importance of information gathering, analysis and use by the project, NASCOP will develop a Computerized Management Information System (CMIS).

It should be noted that a CMIS

- **is not** a means to find faults in the implementation process
- **is not** gathering of information to be used only for research purposes

- **is not** gathering of quantitative information only
- **is** diagnostic (i.e., to identify opportunity gaps in project implementation)
- **is** enabling (i.e., to help bridge opportunity gaps for optimum implementation of the project)
- **is** participatory (i.e., the community, NGOs/CBOs, and County/Sub-County Health Management Teams/TSU are equal partners in monitoring)

In 2013, NASCOP finalized and rolled out programme indicators against which all key population implementers should align their work. These core coverage indicators have been deemed suitable for collection, collation, and reporting from programmes.

All implementing partners need to report against the format in Annex 4.1 every quarter. It is best that the implementing partners share their report with the TSU field officers to ensure that reports are error free to prevent misrepresentation of their efforts. Reports must be submitted by 15th of succeeding quarter.

### 3.8.3 M&E Reporting Tools

In 2014, the NASCOP KP TWG finalized standardized data collection tools and developed a National M&E Field Guideline. The tools include the following:

1. PE Contact Form (a) - FSW/MSM/MSW
2. PE Contact Form (b) - PWID/PWUD
3. PE Outreach Calendar (a) - FSW/MSM/MSW/ Transgender
4. PE Outreach Calendar (b) - PWID/PWUD
5. Summary of Outreach Calendar (a) - FSWs / MSW/ MSM/Transgender
6. Summary of Outreach Calendar (b) - PWID/ PWUD
7. Enrolment Form - MSM/MSW/Transgender
8. Enrolment Form – FSW
9. Enrolment Form - PWID
10. Clinical Visit Form
11. STI Treatment Data Collection Form
12. Hot spot Master List (a) - FSW/MSM/ Transgender
13. Hot spot Master List (b) - PWID
14. Condoms & Lubes Register
15. Condom Outlet Register
16. Needle & Syringe Register
17. Cohort Register
18. Group Meeting Report
19. Advocacy & Event Activity
20. Violence Recording Form
21. Needles & Syringe Returns/Collected Register
22. Training/Sensitization Form

### 3.8.4 Illustrative Project Budget Line Items

| Project Personnel                                                          | Essential | Desirable |
|----------------------------------------------------------------------------|-----------|-----------|
| Programme Personnel Remuneration (excluding local travel costs)            |           |           |
| Programme Coordinator (1)                                                  | ✓         |           |
| Data Officer (1)                                                           | ✓         |           |
| Accountant (1)                                                             |           | ✓         |
| Physician (1) / Clinical Officer                                           |           | ✓         |
| Nurse (1)                                                                  | ✓         |           |
| Counsellor (1)                                                             | ✓         |           |
| Outreach Workers (~ 5)                                                     | ✓         |           |
| Peer Educators (~ 20)                                                      | ✓         |           |
| Office Support Staff (1)                                                   | ✓         |           |
| Project Overheads                                                          |           |           |
| Office Rent                                                                |           |           |
| DIC Rent (one DIC per 1000 population, DIC needs to be close to hot spots) |           |           |
| Office/ DIC running costs (Security, utilities, waste disposal, etc.)      |           |           |

| Project Personnel                                                       | Essential | Desirable |
|-------------------------------------------------------------------------|-----------|-----------|
| Programme Activities                                                    |           |           |
| Community Mobilisation                                                  |           |           |
| DIC event costs                                                         |           |           |
| Hot-spot meeting costs                                                  |           |           |
| Weekly review meeting costs                                             |           |           |
| Monthly review meeting costs                                            |           |           |
| Community Committee monthly meeting costs                               |           |           |
| Service Delivery                                                        |           |           |
| Communication materials costs                                           |           |           |
| Outreach clinics / moonlight service delivery costs                     |           |           |
| Violence response costs                                                 |           |           |
| Enabling Environment                                                    |           |           |
| Barazas / community meeting costs                                       |           |           |
| Advocacy / stake holder meeting costs                                   |           |           |
| Sensitisation of law enforcement agencies and other stake holders costs |           |           |
| Capacity Building/Training                                              |           |           |
| Peer Educators                                                          |           |           |
| Outreach Workers                                                        |           |           |
| Programme Coordinator                                                   |           |           |
| M&E Officer                                                             |           |           |
| Counsellor                                                              |           |           |
| Doctor                                                                  |           |           |
| Medical Inventory                                                       |           |           |
| Condoms                                                                 |           |           |
| Lubes                                                                   |           |           |
| Clinical equipment                                                      |           |           |
| Drugs                                                                   |           |           |

## Key Resources

Balian R and White C. 2010. *Harm Reduction at Work: A Guide for Organisations Employing People Who Use Drugs*. New York, USA: Open Society Foundations. [www.soros.org/reports/harmreduction-work](http://www.soros.org/reports/harmreduction-work)

A World Health Organization *Toolkit for Monitoring and Evaluation of Interventions for Sex Workers* provides an overview of interventions for FSWs and clients, a detailed general approach to effective monitoring and evaluation, recommended indicators and targets, and a guide to the use of monitoring and evaluation data. <http://www.wpro.who.int/hiv/documents/docs/mandetoolkitweb.pdf>

1 STIs in Gay Men Action Group (STIGMA). 2009. *Newsletter #4* (February) [http://stipu.nsw.gov.au/wp-content/uploads/166159\\_STIGMA\\_GP\\_Newsletter4\\_Feb\\_2009.pdf](http://stipu.nsw.gov.au/wp-content/uploads/166159_STIGMA_GP_Newsletter4_Feb_2009.pdf). *Newsletter #5* (October) . [http://stipu.nsw.gov.au/wp-content/uploads/166160\\_STIGMA\\_GP\\_Newsletter5\\_Oct\\_2009.pdf](http://stipu.nsw.gov.au/wp-content/uploads/166160_STIGMA_GP_Newsletter5_Oct_2009.pdf)

# Annexes

## CONTENTS

*Chapter 3 presents the overarching programme coordination and management structures of key population programming from grassroots through to national level.*

- 3.1 Introduction
- 3.2 Programme Science
- 3.3 Planning for Key Population Programme Implementation
- 3.4 The National Key Population Steering Committee
- 3.5 The Role of NASCOP
- 3.6 The Role of County Health Management Teams
- 3.7 The Role of Implementing Agencies
- 3.8 Monitoring and Evaluation
  - 3.8.1 Programme Data for Key Population M&E
  - 3.8.2 Technical Infrastructure
  - 3.8.3 M&E Reporting Tools
  - 3.8.4 Illustrative Project Budget Line Items

# Chapter 1

## 1.1

### HIV EPIDEMIOLOGY

The first step in setting priorities for HIV prevention programmes is to understand the epidemic's distribution and drivers. This involves understanding the transmission dynamics within populations that have the highest HIV prevalence and the highest HIV transmission rates, and the epidemic's potential. Epidemic potential is a broad epidemiological concept that applies to epidemiological heterogeneity.<sup>1</sup>

An HIV epidemic's *potential* is the extent to which it may spread beyond the networks that are directly linked to high-risk subpopulations, and is based largely on the size and distribution of key high-risk subpopulations (e.g., female sex workers, their clients, men and transgender women who have sex with men, male sex workers and their sexual network structure, people who inject drugs and the drug injecting network structure).

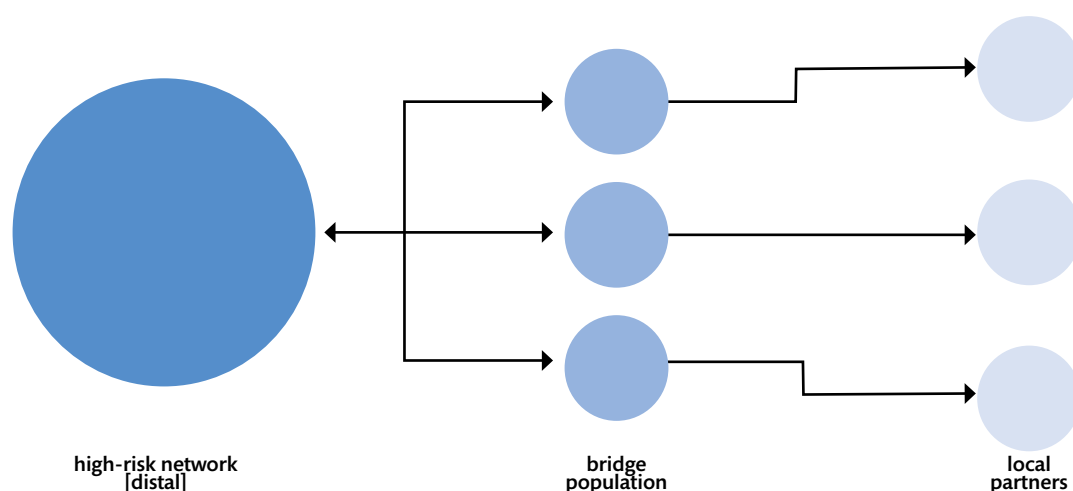
Epidemic potential is further categorized into epidemic typologies, namely, **truncated, local concentrated, and generalized** epidemics, which in turn inform the most appropriate HIV prevention strategies and interventions.

#### Truncated Epidemic

A truncated epidemic is one in which HIV transmission is confined to individuals who participate in non-localized high-risk networks (such as the sex trade) and to their local partners. Non-localized high-risk networks may exist in communities outside of one's typical place of residence, and are connected to local networks through bridge populations, such as migrants who become clients of sex workers when outside of their home communities. HIV transmission may occur among the sexual partners of returning migrants without further amplification by local high-risk transmission networks. Prevention strategies should focus primarily on interrupting transmission at the migration destination location(s), with prevention message reinforcement at the origin and transit points in areas that have large concentrations of out-migrants. Prevention activities at the location of origin should include HIV counselling and testing services for those with high-risk behaviours, as well as care and support services. Figure 1 schematically depicts a truncated epidemic. Truncated epidemics are likely in locations where the local sexual structure does not support much local HIV transmission but where a significant proportion of men out-migrate to areas with extensive sex work networks. Those men may acquire HIV after engaging in high-risk behaviours as part of the networks at their migration destination and then may infect their sexual partners without spreading HIV beyond the partner.

<sup>1</sup> Karnataka Health Promotion Trust. 2012. A Systematic Approach to the Design and Scale-up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers. Bangalore: KHPT. <http://www.khpt.org/reports%20pdf/A%20Systematic%20Approach%20to%20the%20Design%20and%20Scale-Up%20of%20Targeted%20Interventions%20for%20HIV%20Prevention,%20full%20version.pdf>

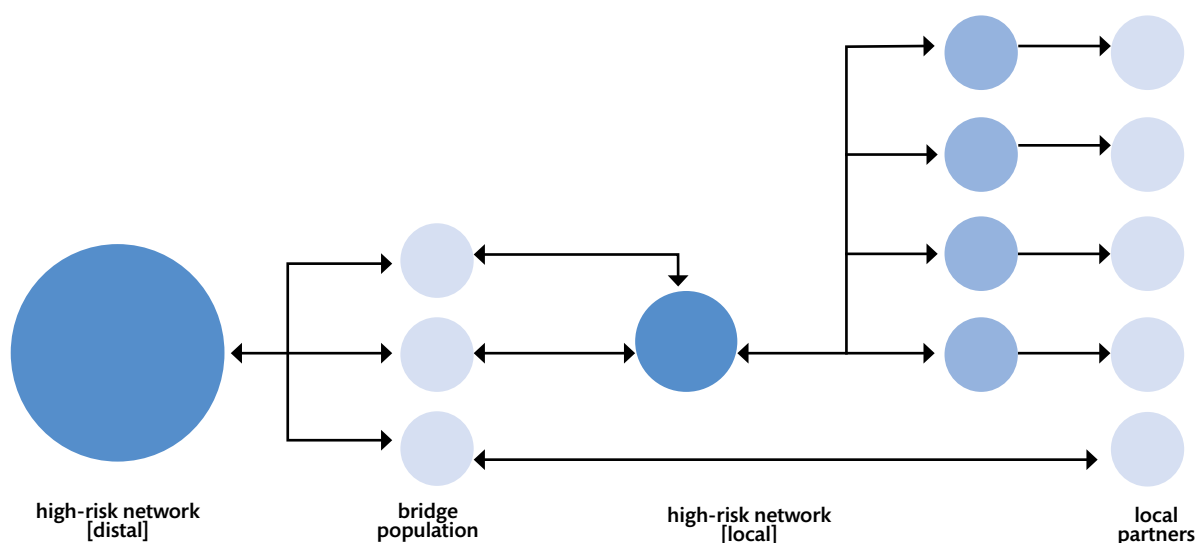
FIGURE 1: **Truncated Epidemic. Adapted from Moses et al. 2006**



## Local Concentrated Epidemic

A local concentrated epidemic is one in which HIV transmission occurs through local high-risk networks and to the wider local population through bridge populations. The size of the high-risk subpopulations and other sexual and drug injecting networks in the local area largely determine the size of the epidemic, but HIV transmission dynamics remain driven by the high-risk networks. Prevention strategies should interrupt transmission within the distal and local high-risk transmission networks. Although HIV prevalence within these high-risk networks reaches high levels, the prevalence in the general population remains relatively low unless a very high proportion of bridge populations engage with high-risk networks. The constraint on overall epidemic growth occurs because of limited transmission between local partners who are independent of high-risk networks. Figure 2 depicts a local concentrated epidemic.

FIGURE 2: **Local Concentrated Epidemic. Adapted from Moses et al. 2006**



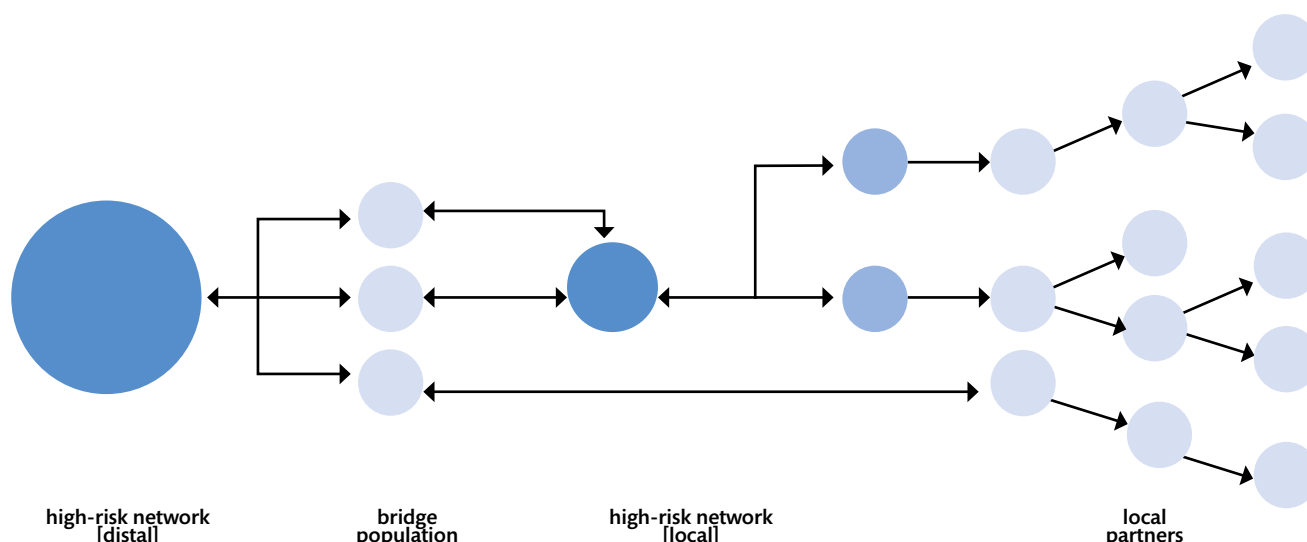
## Generalizing Epidemic

A generalizing epidemic begins in local high-risk networks but spreads beyond the highest-risk networks due to extensive risk behaviours in the wider community, ultimately independently of easily defined high-risk groups. Strategic responses to such situations should include both targeted interventions for high-risk groups and an early emphasis on reducing the potential for transmission in the more general population through enhanced sexually transmitted infection (STI) services, broader behavioural change programmes, and aggressive condom promotion. Figure 3 depicts a generalized epidemic.

Although concentrated and generalized epidemics will generally result in higher HIV prevalence, this measure does not strictly define those typologies. Instead, the transmission structure in terms of behavioural patterns and networks constitutes a distinguishing characteristic.

On the one hand, an epidemic is concentrated if it is driven primarily by high-risk groups and if effective programmes for high-risk groups would reduce overall HIV transmission. On the other hand, an epidemic is generalized if transmission occurs primarily outside high-risk groups and would continue despite effective programmes for high-risk groups. In short, an epidemic is concentrated if stopping high-risk group transmission would control the epidemic, and it is generalized if stopping high-risk groups transmission would not control the epidemic.

FIGURE 3: **Generalized Epidemic. Adapted from Moses et al. 2006**



## Mixed Epidemic

'Mixed' epidemics are a blend between concentrated and generalized epidemics. This means that there are important key populations (formerly referred to as 'most-at-risk populations' or 'MARPs') that contribute substantially to the epidemic, but that control and reversal of the epidemic cannot be fully realized with HIV prevention targeted only to those key populations. Instead, a blend of HIV prevention programmes that focus on key and other vulnerable populations, including key segments of the general population, is required to control the HIV epidemic.<sup>2</sup> This is the programming approach that is applicable to the Kenyan epidemic.

<sup>2</sup> Moses S et al. 2006. AIDS in South Asia Understanding and Responding to a Heterogeneous Epidemic. Washington, D.C.: The World Bank. [http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/Publications/448813-1155152122224/southasia\\_aids.pdf](http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/Publications/448813-1155152122224/southasia_aids.pdf)

# Chapter 2

## 2.1

### GUIDING PRINCIPLES FOR MAPPING:

Five main principles guide the broader mapping process: optimal ignorance, clear definitions and sub-categorical definitions of key populations, participation of stakeholders, protection of key population information, and rapid execution.

- **Optimal ignorance:** Mapping at this level should focus on gathering only information that is critical for making recommendations and decisions during the planning stages of interventions. It should not be used to gather information about behaviours, such as condom use, health seeking, client volume, and harassment.
- **Clear definitions and sub-categorical definitions of key populations:** Key populations need to be clearly defined against typologies before being mapped. This helps those conducting the exercise to know whom to count as appropriate beneficiaries of targeted interventions. For example, who is a sex worker and when is a sex worker classified as being street-based? Who are men and transgender women who have sex with men and are they all at equal risk? Who is classified as a person who injects drugs?
- **Participation of stakeholders and data triangulation:** While mapping provides opportunities for the meaningful participation of local stakeholders, data triangulation ensures that information gathered from one source is verified against that from others. In order to triangulate the data, it is important to have multiple sources of information for mapping:
  - ▶ **Primary stakeholders and key informants:** Key population members and their sexual partners constitute this group of stakeholders. The inclusion of primary stakeholders (including those representative of all the key population sub-categories around the site) in the mapping team adds value to the process. It is practical, as key informants are likely to be more open with primary stakeholders; the latter will have access to key population social networks, and will be more able to identify non-obvious locations. As such, the mapping results will better reflect reality. Additionally, when primary stakeholders are engaged, the process of mapping becomes an intervention in itself—it mobilises local key population clusters to understand and address HIV risks and creates a demand for HIV services. Therefore, while mapping is going on the intervention simultaneously gets underway. Although secondary and tertiary stakeholders may have good information on key populations, they do not possess as full or the same extent of information as key populations themselves. Therefore, in any mapping exercise, more than 60% of respondents (seeking information or being consulted) must be from the key populations and sub-clusters being mapped.
  - ▶ **Secondary stakeholders and key informants:** These are persons who make up or are close to the key populations' occupational or sexual lives or addiction practices. They include bar owners, security guards, cab drivers, pimps, agents, madams, hotel workers, suppliers of injectable drugs and equipment amongst others.
  - ▶ **Tertiary stakeholders and key informants:** This group is constituted by those who have contextual knowledge about the key populations at a town, district or county level. It includes NGOs, CBOs, and local authorities amongst others.

- **Protection of key population information:** These key populations share behaviours that are illegal or stigmatised. Size estimates of these populations may lead to unwanted or inaccurate reporting in the media or a punitive response by law enforcement and/or increased stigma and discrimination. The dissemination and use of the resulting size estimates and the data collected to create the estimates should be used with caution. It is advisable not to consult group representatives known to have adversarial relationships with particular key populations, as this might jeopardize the mapping exercise and cause local key populations actual harm.
- **Rapid execution:** The mapping methodology is designed to be a rapid process of data collection and validation to allow for the design and implementation of programmes without delay, or loss of momentum.

The mapping methodology described below is distinguished from others in terms of scale, detail, and rapidity of implementation. Moreover, this method incorporates standardized methods for the identification and interviewing of key informants and the collation and triangulation of the information collected.

### Outline of Mapping Methodology

#### Pre-mapping preparations:

- Define objectives
- Review existing literature/information
- Involve stakeholders, implementing partners
- Let policy, the community, local service providers, and business owners know that mapping will take place
- Select districts and identify target areas on maps
- Recruit and train field team
- Recruit and train peer key informants
- Define roles and responsibilities
- Define key concepts and terms with stakeholder input
- Design ongoing monitoring and quality assurance mechanisms for implementation during data collection
- Collect data (rapid, minimalistic, practical)

#### First-level data collection to determine

- Locations frequented by key populations
- Key population size
- Pre-existence of macro-level coverage

#### Second-level data collection to obtain specific details about locations and 'hot spots', including

- The number of key population members who work/congregate there on a typical day
- The general organizational typology of key populations
- The presence of any additional locations or hot spots not previously identified
- Data collection
- Data collection for validation
- Data triangulation
- Data management, analysis, report preparation and dissemination

**It is important to remember that size estimation requires ethical approval and should be conducted with inputs from experts, key populations, and other stakeholders.**

## Advantages and Limitations of the Methods for Size estimation

The table below provides an overview of the different methods and their advantages and disadvantages. Use this table as a quick reference when choosing a size estimation method. A thorough review of these methods, their strengths and limitations, and how to implement them, can be found in the 2010 WHO/UNAIDS Guidelines on Estimating the Size of Populations Most at Risk to HIV.

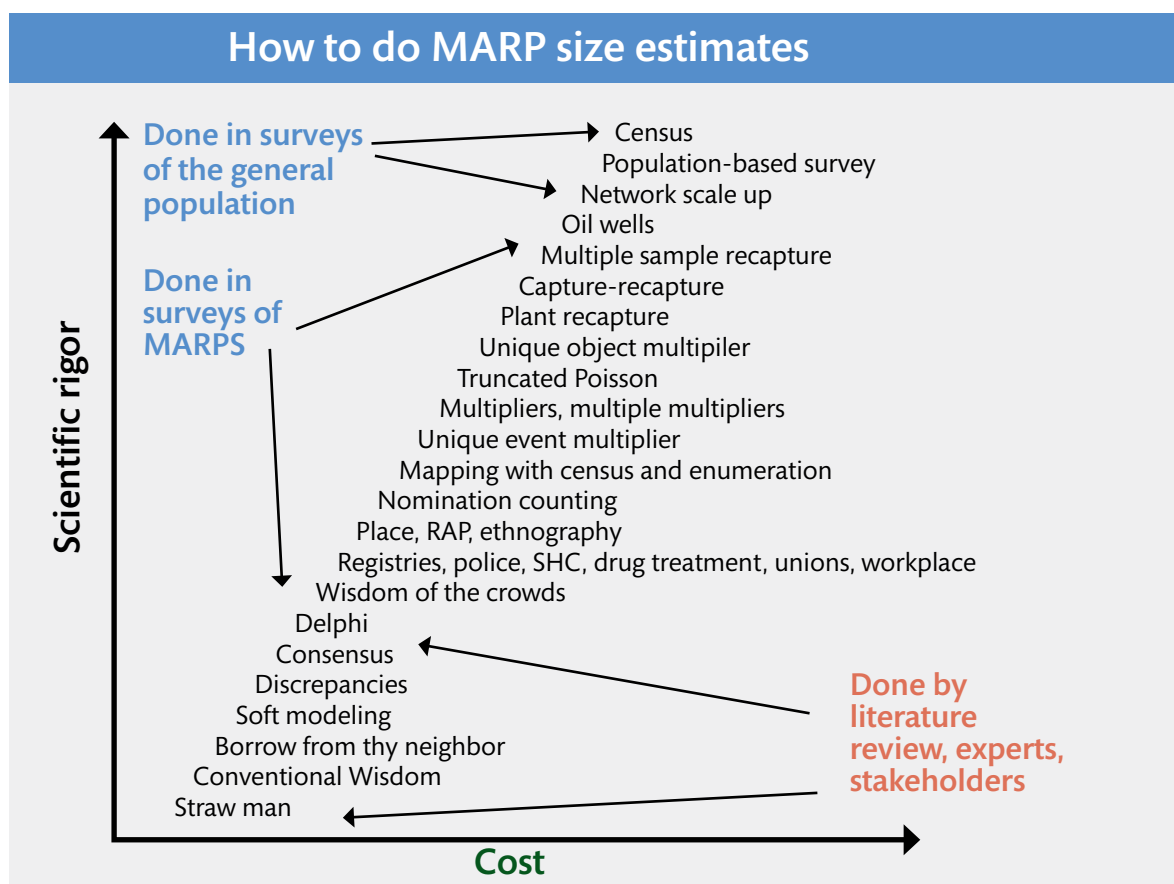
| Size estimation methods based on data collected from key populations |                                                                                                                                                                                                                        |                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Method                                                               | Description                                                                                                                                                                                                            | Strengths                                                                                                                                  | Limitations                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Census                                                               | Census counts all members of the population                                                                                                                                                                            | <ul style="list-style-type: none"> <li>• Straightforward to calculate</li> <li>• Easily understood by non-public health experts</li> </ul> | <ul style="list-style-type: none"> <li>• Expensive and time-consuming</li> <li>• Not effective for geographically dispersed key populations</li> <li>• For hard to reach population, this method tends to underestimate population size</li> <li>• Overestimate if population is mobile</li> </ul>                                                                                                                                                            |
| Enumeration                                                          | Enumeration maps an area, counts a fraction of individuals in the selected area, then inflates the value to create an estimate                                                                                         | <ul style="list-style-type: none"> <li>• Straightforward to calculate</li> <li>• Easily understood by non-public health experts</li> </ul> | <ul style="list-style-type: none"> <li>• Less expensive than census</li> <li>• Highly dependent on completeness of mapping</li> <li>• For hard to reach population, this method tends to underestimate population size</li> </ul>                                                                                                                                                                                                                             |
| Capture-recapture                                                    | Calculates the total size of a population based on two independent captures of population members. The number of members captured in both samples is used to derive an estimate of the total number in the population. | <ul style="list-style-type: none"> <li>• Relatively easy to implement</li> <li>• Does not require much data</li> </ul>                     | <ul style="list-style-type: none"> <li>• Relies on assumptions that are hard to meet:</li> <li>• two samples must be independent and not correlated</li> <li>• each population member has an equal, or known, chance of selection</li> <li>• each member must be correctly identified as 'capture' or 'recapture'</li> <li>• no major in/out migration may occur</li> <li>• the sample sizes of each capture must be large enough to be meaningful</li> </ul> |

|            |                                                                                                          |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                      |
|------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Multiplier | Compares two independent sources of data for populations to estimate the total number in the population. | <ul style="list-style-type: none"> <li>Where data is available, this method is straight forward.</li> <li>Preferred to census or enumerator when sampling frame is questionable or population hard to reach.</li> <li>This method is flexible</li> </ul> | <ul style="list-style-type: none"> <li>Highly dependent on the quality of existing data</li> <li>The two data sources must be independent</li> <li>The data sources must define population in the same way</li> <li>Time periods, age ranges, geographic areas must align</li> </ul> |
|------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### Size estimation methods based on data collected from the general population

| Method            | Description                                                             | Strengths                                                                                                                                                                                                                                                      | Limitations                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Population Survey | Includes questions on high-risk behaviours in general population survey | <ul style="list-style-type: none"> <li>Surveys are common and familiar</li> <li>Straightforward to analyse and explain data</li> </ul>                                                                                                                         | <ul style="list-style-type: none"> <li>Not as useful when behaviour is rare or stigmatized</li> <li>Reaches only individuals in households, schools, etc.</li> <li>Individuals must self-identify as key populations</li> </ul>                                                                                                                                                          |
| Network scale-up  | Includes questions on high risk behaviours of respondents               | <ul style="list-style-type: none"> <li>Does not require KPs to identify themselves</li> <li>Individuals are more likely to report the behaviour of others than their own behaviour</li> <li>Multiple key populations can be estimated in one survey</li> </ul> | <ul style="list-style-type: none"> <li>Average personal network size is difficult to estimate</li> <li>Subgroups may not associate with members of the general population.</li> <li>Respondent may be unaware someone in his/her network engages in behaviour of interest.</li> <li>Respondents may be hesitant to admit to knowing individuals with the specified behaviour.</li> </ul> |

Other methods exist to document the size of a population. There is no gold standard in choosing a mapping methodology. Programmers should consider which methodologies are contextually and financially feasible. Figure 4 outlines some of the methodologies in use.

FIGURE 4: **Size Estimation Methods**

In Kenya, between 2009 and 2013, the number of implementing partners working with key populations increased from nine to around 70 within an unstructured framework. For the purposes of national and county-level coordination, harmonization of efforts, and further scale-up, it is important that new and existing implementing partners be engaged in a standardised process of key population mapping, in close collaboration with NASCOP.

If implementing partners know how and why information is being gathered in a particular way, they will trust the information and confidently use it to shape their intervention design, which in turn will inform sustainable national-level programming. Implementing partners' familiarity with key populations will inform the design of appropriate and effective county-level programmes. By witnessing the competence with which key population peers undertake mapping, implementing partners will also be convinced of the importance of key population peers as allies in local interventions.

While a standardized level of implementing partner involvement in mapping is the ideal, different implementers may be in different stages in their programme cycles, and coverage of key populations may vary regionally. As such:

Key population programmers should bear in mind that mapping is not formal research or ethnographic study. The information it generates can (a) be limited to informing the design or review of local HIV interventions and (b) be site-specific and therefore not generalizable to other sites. Programmers should also bear in mind that size estimates are just that – they are not an exact headcount of individual key population members. As previously mentioned, constant turnover/mobility of some key populations warrants periodic revision of mapping estimates over the course of programme implementation.

Implementing partners should endeavour to do no harm. As mapping is an integral part of the national plan of operations, it must be implemented in a way that reflects and reinforces the core values and approaches of NASCOP and NACC, ensuring the well-being and protecting the rights and concerns of key populations. During mapping, it is important to remember the hidden, socially marginalised, and criminalised status of key populations and the practices that they engage in. To protect key population participants in mapping, the following precautions are to be taken:

- Do not breach confidentiality of key population members.
- Seek the consent of key population members before involving them in mapping.
- Be prepared to handle negative consequences of mapping for key populations (have a damage control plan).
- Do not raise false expectations (e.g., promise of services, jobs, or remuneration).

## Steps to Ensure Protection of Key Populations during Mapping

1. Access to key populations may require going through gatekeepers such as employers, brothel owners, pimps, and peddlers. Mapping teams will hold discussions with gatekeepers and explain the purpose and parameters of the mapping (e.g., size estimation, service providers to key populations, places where key population members operate, and other information to guide the design of HIV interventions or to improve the implementation of on-going projects). Gatekeepers will be assured that all information gathered by the mapping team will be kept anonymous and confidential and will not be shared, even with them.
2. Specific effort will be made to inform the NGOs working with the key populations covered by the mapping, as well as community leaders, about the purpose, risks, and benefits of the mapping.
3. The mapping is anonymous. No names or personal identifiers will be recorded. Mapping teams and others associated with mapping must ensure that mapping records are kept secure throughout the mapping process and after.
4. Mapping teams will have to take witnessed verbal consent from each participant before they involve him/her in the process. All mapping documents and information will be labelled in such a way that the participants remain anonymous. Prior to implementation of any mapping procedure or method, those who are implementing it will explain the mapping procedures in detail to potential participants, and answer all questions to the full satisfaction of the participants. The mapping team will emphasise that participation is voluntary, and that participants who decline to participate or who withdraw from the process will remain eligible for services from the NGO or the clinic.
5. Mapping teams will closely monitor the consent procedure through spot checks.
6. Before any dissemination of mapping data, discussions will be held between NASCOP, the mapping team, and local NGO/CBO staff and community leaders on the potential use of information for programming when the mapping is complete.
7. Implementers of mapping will adopt stringent measures to ensure that participation in mapping does not expose key population members to any risk or cause them any harm. Furthermore, it is essential to specify action that would be taken to mitigate harm and support key population participants if anything untoward occurs.

These steps are necessary not just to mitigate material harm (e.g., money to compensate for loss of work or other support such as legal aid, safe custody, etc.) but also to establish that the national strategic plan respects the rights and entitlements of key population participants and acknowledges that any harm to them ought to be substantively redressed.

## 2.2

### TOOLS FOR MICRO-PLANNING

#### 2.2.1 Site Load Mapping

Site Load Mapping helps the key population programmes to understand and list the venues/ hot spots / injecting sites where key populations solicit, cruise, and/or inject, and also to assess the normal day and busy day key population loads in each of the sites.

**Suggested Method:** Group discussion and group work that include key populations and the peer educators

**Materials/Preparation Required:** Chart paper and marker pens

**Process:**

1. Explain to the participants that in order to reach out to key populations, it is important to know where and how many are available on a normal day and a busy day.
2. Ask the participants according to sites/ hot spots to complete the following steps:
  - a. Draw a map of their town or locality, and then clearly depict the sex work hot spots, or the sites at which key populations solicit their clients or inject. If drawing is an issue, then the participants can list the hot spots.
  - b. Colour code the sites based on key population typology.
  - c. Write the number of key populations who are typically present on a normal day at/around the site.
  - d. Write the number of key populations typically present at these sites on a busy day. If there are any specific days in a week when the number of key populations peaks, include this and the reasons why (e.g., more key populations are present on a market day).
  - e. Add the normal-day and busy-day turnover<sup>3</sup> in all the sites to give a picture of key population turnover in a site.
  - f. Compare these figures with their estimate, unique contact, and regular contact figures for these sites, if available, and analyse this information in the following way:
    - i. Are the total key populations available in these sites more or less than the unique contacts and regular contacts? Why?
    - ii. Are normal day or busy day turnover linked with any specific typology of key populations? For example, is there high turnover seen in mostly street-based sex work or venue-based sex work? Why?

<sup>3</sup> Turnover is defined as the number of key population members who operate from that site during any specified period (e.g., day, week or month).

- iii. Are there specific sites where unique contact and regular contact is less than monthly turnover? Why?
  - iv. Which are the sites and typology of sex work that need focused outreach?
  - v. Who (outreach team) is responsible for these specific sites?
  - vi. What should they do to improve outreach to ensure higher contacts?
3. Ask each group to share their process, analysis, and learning in plenary.

### 2.2.2 Contact Listing

Contact listing helps peer educators to map their contacts within the sex work community and based on this understanding, plan outreach in different sites or hot-spots.

**Suggested Method:** Large group discussion

**Materials/Preparation Required:** Chart paper and marker pens

**Process:**

1. Begin the session by informing the peer educators that both geographic networks and social networks of peer educators play an important role in helping the outreach workers and peers to plan and deliver outreach to key populations.
2. Ask all peer educators to list all of their contacts on a flipchart paper.
3. Then ask the peer educator to write the name of the hot spot against each key population contact he/she has listed in the chart paper.
4. Count the contacts of each peer educator for each hot spot.
5. Check all chart papers to identify a group of peer educators know key populations in a particular hot spot.
6. If there are common hot spots where two or more peer educators know their contact, then bring together those peer educators to see if their contacts are known to other peer educators or are unique.
7. Then, based on the contacts and in discussion with the peer educators, allocate that particular hot spot to the peer educator who has the highest contacts.
8. Repeat the exercise for all hot spots that have contacts with two or more peer educators.

**Note:** Ensure that for each hot spot there is a designated peer educator based on her contacts. Have two or more peer educators working in a hot spot if the estimates are more than 60 key populations.

### 2.2.3 Peer Plan

A hot-spot-based peer plan is the core micro-planning tool that is developed by a peer educator for the hot spot and the FSWs/MSM/PWIDs he or she works with. This tool helps peer educators plan their

outreach at the appropriate time, day, and place. It also helps peer educators understand the relative risk of each individual they reach out to, and calculate individualized weekly and monthly distribution targets for the prevention commodities that the key population members need. Site-based peer plans tell peer educators what they must achieve, and help the outreach team to support the peer educators.

**Materials Required:** Chart papers, colour pens

**Participants:** Peer educators, outreach workers, and programme manager or coordinator

FIGURE 5: Peer Plan

| PEER EDUCATOR OUTREACH PLAN | NAME           | RISK LEVEL | TYPOLOGY |
|-----------------------------|----------------|------------|----------|
| (1) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.7        | 2        |
| (2) KHA ANHE (BAR)          | KHA ANHE (BAR) | 3.1        | 6        |
| (3) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.8        | 6        |
| (4) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.4        | 8        |
| (5) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.4        | 7        |
| (6) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.0        | 5        |
| (7) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.5        | 8        |
| (8) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.0        | 5        |
| (9) KHA ANHE (BAR)          | KHA ANHE (BAR) | 2.5        | 8        |
| (10) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (11) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (12) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (13) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (14) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (15) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (16) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (17) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (18) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (19) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (20) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (21) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (22) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (23) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (24) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (25) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (26) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (27) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (28) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (29) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (30) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (31) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (32) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (33) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (34) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (35) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (36) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (37) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (38) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (39) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (40) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (41) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (42) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (43) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (44) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (45) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (46) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (47) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (48) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (49) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |
| (50) KHA ANHE (BAR)         | KHA ANHE (BAR) | 2.5        | 8        |

### Process:

1. Explain to the peer educators the importance of planning outreach. Stress that, in order to extend adequate services to the entire community, each peer educator should understand what time key population members are available in a given site and each individual's risks. Such knowledge enables peer educators to plan when and where to meet key population members and how many commodities each community member should be given.
2. This exercise is led by peer educators, with other project staff (from community or non-community) being passive participants.
3. Each peer educator takes a sheet of flipchart paper and writes down (him/herself with help of project staff) the name of each site that he/she services.
3. Then, for each site the peer educator writes the names of key population members who operate from that site.
4. Female sex workers
  - a. Once the names are listed, the outreach worker asks the peer educators to specify the typology of each sex worker on their list and indicates the typology of each FSW on the list with a colour code.

- b. Then the outreach worker again goes through the list and asks the peer educator about the number of sex acts that each listed FSW has every week. This number is plotted using colour dots beside each sex worker's name.
5. Men and transgender women who have sex with men
  - a. Once the names are listed, the outreach worker goes through each MSM and TG name on the list and asks the peer educator to name each person's MSM or TG typology. Using colour codes, each individual's typology is indicated.
  - b. Then, the outreach worker again goes through each MSM and TG on the list and asks the peer educators if the person generally has sex for money. This again is marked with a colour dot. Similar process is done to label MSM and TGs who generally have anal sex.
  - c. Then, the outreach worker asks the peer educator about the number of each MSM and TG's anal sex encounters and oral sex encounters, and this information is added as a corresponding number of coloured dots for each individual.
6. People who inject drugs
  - a. Once the names are listed, the outreach worker goes through each IDU name on the list and asks the peer educator how many times the IDU injects in a given day.
  - b. The outreach worker also checks if the IDU injects daily or only on particular days.
  - c. From the above, total injecting episodes are calculated weekly and monthly.
7. For each site, the outreach worker asks peer educators the peak cruising times / best times for outreach. These are noted along each site.
8. Finally, the outreach team discusses with the peer educator the best days for outreach for a particular site. This is also recorded in the peer plan.
9. It is to be ensured that all sites are visited at least once every week, with most time being spent in the biggest sites.
10. Finally, analyse the site-based peer plan to understand who is at higher or lower risk, and to learn each individual's need for condoms, lubricant, needles, or syringes.
11. Calculate how many condoms, lubricants, needles, and syringes each peer educator should distribute to the key populations. These quantities must be supplied to the peer educators for distribution. Tabulate all peer plans to arrive at overall condom/lubricant requirement and to consolidate the overall outreach plan for the programme.

**Note:** A site-based peer plan is a visual exercise done by the peer educators and volunteers and facilitated by the outreach team. Information generated from a peer plan is sensitive and should be used for outreach delivery purposes only. Peer plans should not be publicly displayed and should be kept safely.

## 2.2.4 Opportunity Gap Analysis

A tool to continuously improve programming related to the uptake of services is Opportunity Gap Analysis. Opportunity gaps are obstacles that increase the proportion of key populations who are not engaged in the various stages of the prevention programme. Opportunity gaps are defined by the number of key populations who have not received or are not currently receiving key outreach and service delivery programme components. On-going monitoring of opportunity gaps is recommended so the identified obstacles can be continuously assessed. Once these opportunity gaps are identified, efforts should be made to eliminate or reduce them to facilitate increased programme uptake.

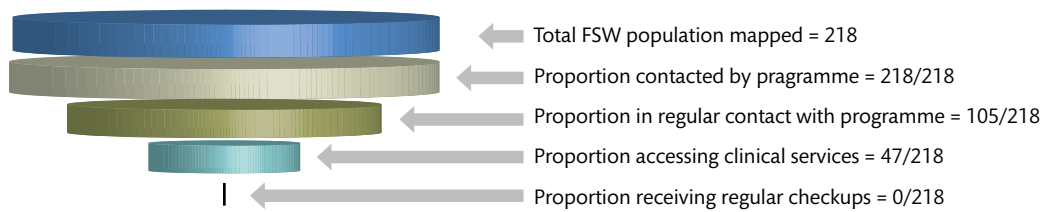
A set of pre-identified indicators as finalized by NASCOP that reveal programme coverage gaps can trigger changes in the programme to address such gaps and improve coverage. The particular indicators used depend on the specific programme configuration and should be identified in the process of development of the programme 'logic model'. The goal is to have in place a reliable system to continually identify programme and service gaps at all levels in order to ensure the continuous iterative refinement of interventions using this information.

**Suggested Method:** Group work and discussion

| Indicator                    | Description and Benchmarks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mapping Estimates            | Estimate the number of key population active in a particular site.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Ever Contacted               | At least one face-to-face contact with a uniquely identified key population. If the programme has made 100 unique contacts, it means that outreach staff has met at least 100 different members of the FSW community at least once.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Enrolment with the Programme | After building rapport with the key population, individuals are asked to enrol by filling out the enrolment form. This assigns a unique identification number to the key population member and helps the programme track outreach provided. Key population enrolment usually happens after 1–3 contacts in the field.                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Regular contact              | Every key population member is receiving health education regularly (once every month) and is receiving sufficient condoms for their estimated/reported client/partner interaction. Condom distribution is accompanied by demonstration and training in negotiation skills, if needed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Clinic visit                 | An outreach worker or peer educator refers FSWs for clinical services. At the time of referral, the FSW should be given STI information, condom information and demonstration, distribution of condoms, and the address of an STI/DiSC (Drop-in service centre) clinic. The clinical staff provide syndromic case treatment for STI. Complete STI treatment includes the following components: understanding the symptoms, clinical examination, prescription or distribution of drugs, partner notification and/or treatment, risk assessment and risk reduction counselling by the doctor or the counsellor, with condom demonstration, and distribution. Referral to the clinic needs to be done whenever a key population member is due for clinic visit. |
| HTC                          | Every high-risk HIV-negative key population member is expected to test for HIV every three months. Ideally, an outreach worker or peer educator refers FSWs to the clinic, where she receives counselling and is referred for testing.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

Tracking outreach and service provision on an individual basis enables peer educators to identify FSWs who have not been met, have missed services, or have received insufficient condoms. Peer educators use this information to plan their daily and weekly activities so as to eliminate opportunity gaps within their own outreach. Field coordinators and programme managers use aggregate data on outreach and service gaps from each location, town, and district to ensure that the entire key population is reached and served (illustrated by Figure 6).

FIGURE 6: Illustrative Example of Opportunity Gaps

**Process:**

Explain to the outreach team that it is important to periodically analyse their records in order to learn what the project has been able to achieve and what it has not been able to achieve. This analysis should be done for each hot spot since every hot spot is unique and hence needs a specific outreach plan.

Opportunity gap analysis is performed in the following steps:

1. Peer educators compare their outreach records with their peer plan to learn whether any key population members are not being contacted.
2. Peer educators compare their outreach records with their peer plan to identify key population members who are using fewer services than they should use.
3. For each key population member who has not been adequately contacted or who has not used a programme service, the peer educator identifies the reason.
4. The peer educator then makes a plan to address the causes of opportunity gaps.

One of the objectives of the project is saturation coverage to ensure that all key populations in every spot are reached with information and services. Outreach aims to change the following behaviours of the FSWs:

- From low/no condom use to correct and consistent condom use
- From low/no STI treatment to early, timely, and complete treatment
- From poor health-seeking behaviours to quarterly regular health check-ups

Hence to attain this behaviour change, various outreach processes take place in the field. These are as follows:

- Contact with key populations at the field
- Enrolments (at field and clinic)
- Regular contact (meeting key populations every month with programmes and services)
- STI treatment (once in a quarter)

However during these processes in the field there are dropouts, and that is what we call opportunity gaps. It is important to analyse the reasons for these gaps along with the community to develop an efficient outreach plan which is responsive to the needs of the community.

## 2.2.5 Site or Hot Spot Analysis

Site or Hot Spot Analysis enables peer educators to compile and analyse all the information they have about a site/ hot spot and plan outreach based on the analysis.

**Suggested Method:** Large-group discussion and small-group work

### Process:

Clarify the importance of micro-planning for HIV prevention programmes. A site/ hot spot is the smallest geographic location for intervention; therefore, it is important to develop a micro-plan for every hot spot / site. Characteristics such as client volume and typology of sex work have to be factored into planning.

1. Ask participants to form groups. Ask each group to identify a well-known site in their city/area/zone.
2. Ask the groups to analyse their site using the following criteria:
  - a. Typology of sex work: street, venue, etc.
  - b. Client volume of sex workers frequenting their site
  - c. Age of sex workers frequenting the site
  - d. Time of sex work – morning, afternoon, etc.
  - e. Frequency of sex work: daily, weekly, monthly

Assist the peer educators in this exercise

FIGURE 7: Site Analysis Tool

MILLENNIUM SPOT ANALYSIS : 300 FSW

TARGET 300 FSW

| BELOW 25 yrs |        |         | 25-35 yrs |        |         | 35 yrs + |        |         |
|--------------|--------|---------|-----------|--------|---------|----------|--------|---------|
| DAILY        | WEEKLY | MONTHLY | DAILY     | WEEKLY | MONTHLY | DAILY    | WEEKLY | MONTHLY |
| 20           | 30     | 50      | 50        | 50     | 50      | 10       | 20     | 20      |
| M            | E      | M       | M         | E      | M       | E        | M      | E       |
| 5            | 15     | 10      | 20        | 10     | 40      | 10       | 40     | 20      |
| 30           | 20     | 30      | 5         | 5      | 15      | 5        | 15     | 5       |

VIOLENCE — MODERATE.

CLIENT VOLUME — HIGH

RATIO 1 FSW 10 CLIENTS PER DAY.

## 2.3

### PEER PROGRESSION PATHWAYS

| Growth Progression               | 1st Stage (Initial)                                                                                                    | 2nd Stage (Growth)                                                                                                                                     | 3rd Stage (Growth)                                                                                                                          | 4th Stage (Mature)                                                                                                                                 |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Horizontal growth within project | <ul style="list-style-type: none"> <li>Community member</li> <li>Peer volunteer</li> </ul>                             | <ul style="list-style-type: none"> <li>Active member</li> <li>Community guide</li> <li>Peer educator</li> </ul>                                        | <ul style="list-style-type: none"> <li>Peer educator</li> <li>Core Committee member</li> <li>Peer guide</li> </ul>                          | <ul style="list-style-type: none"> <li>Coordinator of committees</li> <li>Advisory group member</li> <li>Peer mentor</li> </ul>                    |
| Vertical growth within project   | <ul style="list-style-type: none"> <li>Community volunteer</li> <li>Peer volunteer</li> </ul>                          | <ul style="list-style-type: none"> <li>Peer educator</li> <li>Peer co worker</li> </ul>                                                                | <ul style="list-style-type: none"> <li>Sub Committee member</li> <li>Team member</li> </ul>                                                 | <ul style="list-style-type: none"> <li>Coordinator of core committee</li> <li>Team member and leader</li> </ul>                                    |
| Across boundaries                | <ul style="list-style-type: none"> <li>At project/ programme level</li> <li>Participant as community member</li> </ul> | <ul style="list-style-type: none"> <li>Between Projects</li> <li>Peer educator</li> <li>Core Committee member</li> <li>Community consultant</li> </ul> | <ul style="list-style-type: none"> <li>At Programme Level</li> <li>Sub Committee member</li> <li>Advisor – community development</li> </ul> | <ul style="list-style-type: none"> <li>At Programme Level</li> <li>Coordinator</li> <li>Programme mentor</li> <li>Advisory group member</li> </ul> |

### 2.3.1 Peer Progression Framework (active community member)

| Type                                                           | Definition/<br>Selection Criteria                                                                                                                                                                                               | Selection Process                                                                                                      | Role                                                                                                                                                                                                                     | Remuneration            | Possible Next<br>Step - (Career<br>Path)                                                                                                                                               | Possible<br>Capacity-<br>Building Inputs                                                                                                                                                             | Performance<br>Indicators for<br>Consideration<br>for Next Level<br>(Qualitative<br>aspects are more<br>important than<br>quantitative.)                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Community<br>member<br>actively<br>supporting<br>the programme | <ul style="list-style-type: none"> <li>Engaged in sex work</li> <li>Operates from specific geographic area</li> <li>Self-identifies as a sex worker among other female sex workers (if not among the broader public)</li> </ul> | Recommendation by group of female sex workers operating from a locality or type of operating system, e.g. street-based | <ul style="list-style-type: none"> <li>Participates in the process of the project</li> <li>Selects peer educators</li> <li>Supports peer educators in fulfilling their responsibilities</li> <li>Flags issues</li> </ul> | No remuneration offered | <ul style="list-style-type: none"> <li>Active member of the local group (Guide)</li> <li>Peer educators</li> <li>Member of CBO</li> <li>Member of key population Committees</li> </ul> | <ul style="list-style-type: none"> <li>Orientation to the project</li> <li>IPC for safe sex practices</li> <li>Discussions on rights of female sex workers</li> <li>Build advocacy skills</li> </ul> | <ul style="list-style-type: none"> <li>Participates actively in project activities for at least three months</li> <li>Articulates community needs in meetings</li> <li>Demand for health services, condoms increases</li> <li>Responds to the common cause (e.g. intervenes in case of violence against a key population member, helps other key population members access services)</li> </ul> |

### 2.3.2 Peer Progression Framework (active group member)

| Type                                  | Definition/<br>Selection<br>Criteria                                                                                                                                                   | Selection Process                   | Role                                                                                                                                                                                                                                       | Remuneration                                                             | Possible Next<br>Step (Career<br>Path) | Possible<br>Capacity-<br>Building Inputs                                                                                                                                                                                                                                                                                                     | Performance<br>Indicators for<br>Consideration<br>for Next Level<br>(Qualitative<br>aspects are more<br>important than<br>quantitative.)                                                                                       |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Active member of<br>the group (Guide) | <ul style="list-style-type: none"> <li>Supports all the activities of the project locally</li> <li>Comparatively long experience in the community</li> <li>Commands respect</li> </ul> | Consultation with community members | <ul style="list-style-type: none"> <li>Guides community members and peer educators on critical issues</li> <li>Motivates community members to participate in the project process</li> <li>Mediates in local conflict resolution</li> </ul> | No remuneration offered except TA and nominal compensation for wage loss | Peer educators                         | <ul style="list-style-type: none"> <li>Community mobilisation skills</li> <li>Opportunities to participate in formal and informal Sub County level activities</li> <li>Develops understanding of issues and structures pertaining to key populations</li> <li>Develops advocacy skills</li> <li>Develops crisis management skills</li> </ul> | <ul style="list-style-type: none"> <li>Continues to associate with the project for six months</li> <li>Motivates five community members to participate</li> <li>Is not burdened with self- or social stigmatisation</li> </ul> |

### 2.3.3 Peer Progression Framework (Peer educator)

| Type          | Definition/<br>Selection Criteria                                                                                                                                                                                                                                                   | Selection Process                                                     | Role                                                                                                                                                                                                                                                                                                                                                                       | Remuneration                                                       | Possible Next<br>Step (Career<br>Path)                                                                   | Possible<br>Capacity-<br>Building Inputs                                                                                                                                                                                                                                                                         | Indicators for<br>Consideration<br>for Next Level<br>(Qualitative<br>aspects are more<br>important than<br>quantitative.)                                                                                                                                      |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Peer Educator | <ul style="list-style-type: none"> <li>Selected by the community as representative</li> <li>Understands community issues</li> <li>Good relationship with key populations, communication skills, respect for others</li> <li>Expresses interest in representing community</li> </ul> | Through internal consultation/<br>election by<br>community<br>members | <ul style="list-style-type: none"> <li>Link between the community and project</li> <li>Represents and addresses community grievances, problems and needs</li> <li>Attends peer education meetings and workshops organised by other partners</li> <li>Participates in decision-making on the processes of projects</li> <li>Delivers services to key populations</li> </ul> | As per the agreed peer education honorarium in national guidelines | <ul style="list-style-type: none"> <li>Committee member</li> <li>ORW</li> <li>Project Manager</li> </ul> | <ul style="list-style-type: none"> <li>Rights issues</li> <li>Skills development in leadership, communication</li> <li>Opportunities to participate in formal and informal Sub County- level activities</li> <li>Dealing with authorities</li> <li>Conflict resolution/ advocacy</li> <li>Performance</li> </ul> | <ul style="list-style-type: none"> <li>Attends most peer education meetings</li> <li>Brings community issues forward for discussion</li> <li>Leads/mobilises community members in crisis situations</li> <li>Confidently interacts with authorities</li> </ul> |

### 2.3.4 Peer Progression Framework (committee member)

| Type                | Definition/<br>Selection Criteria                                   | Selection Process                                  | Role                                                                                                                                                                                                                                                                                                                                                                                                       | Remuneration    | Possible Next<br>Step (Career<br>Path) | Possible<br>Capacity-<br>Building Inputs                                                                                               | Performance<br>Indicators for<br>Consideration<br>for Next Level<br>(Qualitative<br>aspects are more<br>important than<br>quantitative.)                 |
|---------------------|---------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Committee<br>Member | Member of the<br>peer educators<br>group who serves<br>on committee | By election for a<br>period of one or<br>two years | <ul style="list-style-type: none"> <li>Plans, supervises and guides activities of respective committee, e.g. DIC, STI clinic, etc.</li> <li>Facilitates formation of local group/CBO</li> <li>Represents peer educators /community members in meetings and workshops and gives them feedback</li> <li>Addresses barriers at peripheral level</li> <li>Analyses, prioritises and resolves issues</li> </ul> | No remuneration |                                        | <ul style="list-style-type: none"> <li>Management skills</li> <li>Assessment of project activities</li> <li>Advocacy skills</li> </ul> | <ul style="list-style-type: none"> <li>Identifies gaps in the programme</li> <li>Assesses activities/ provides input</li> <li>Problem-solving</li> </ul> |

## 2.4 Professional Outreach Conduct and Boundaries

All outreach staff, especially those who are not from the key population, must undergo training before embarking on outreach among key populations. This should include training on the practicalities of delivering outreach as well as instruction on all project codes of practice/guidance and policies on outreach. Some projects, as part of the induction process, ensure that outreach workers have shadowed experienced staff before working in outreach teams.

Professional working standards are important for the smooth running of an outreach service and the safety of everyone concerned. All service users should be treated equally and non-judgmentally, recognising and respecting a person-centred approach and diversity. Project staff should not be patronising. Good practice in providing outreach services for PWID are described in the Key Resource mentioned below.

Cold contacts: the first contact with a key population member will determine if or how they will interact with project personnel in the future. Outreach staff should

- Be polite and friendly.
- Explain who they are, why they want to speak to the key population member, and what they have to offer.
- Take the lead from the key population member and not be pushy as it may create resistance.
- Bear in mind that the key population member may or may not know them and may be suspicious of their motives. As such, if they don't want to engage during the first encounter, they may do so the next time.
- Carry official ID.

A trusting relationship has to be developed with key population members before they will engage with the project. Service users need to understand and endorse the aims of the project. Developing and maintaining this can take time but is essential for enabling contacts. Key population members often engage with projects through personal recommendations. Other service users often act as referees or gatekeepers and help in building relationships.

**Be proactive:** Outreach staff should try to talk to key population members and spend time with them. Some people may seem unapproachable. Developing a relationship over time may be more effective than trying to talk to people who do not want to engage in conversation straight away. At the very least, outreach staff should

- Be friendly and approachable.
- Use the name that the key population member gives when they introduce themselves. Abbreviations/ nicknames may not be welcome.
- Not give information or advice if uncertain about the facts. Be genuine, say that they are unsure and will find out and revert with the correct information.

If outreach staff suspect criminal activity is going on, they should distance themselves from the scene. When already criminalized key population members are interacting with the police, outreach workers should try to avoid intervening unless necessary, and then only enquire what is going on and whether they can be of help. Outreach workers should not obstruct the police in the course of their duty. Outreach workers should ensure that supporting key population members does not involve further breaking the law. They should not 'look after' key population members' possessions, or let them prepare/use drugs in the

outreach vehicle. If a key population member is incoherent under the influence of substances, it may not be the best time to discuss issues or make appointments.

**Confidentiality:** Outreach staff should not reveal that somebody is a key population member, even if they are with another member, unless staff are certain that the individual is comfortable with such disclosure. Outreach workers should

- Be discreet and take the lead from the service user. Also, they should never discuss one service user with others. This breaches confidentiality and can also make the service user lose trust in them as outreach workers and in the programme.
- Maintain honest and genuine communication with service users at all times, within a professional context, and be sure not to promise something that cannot be fulfilled.
- Use self-disclosure appropriately with service users. Stick with their agenda and not a personal one.

**Language:** Outreach workers need to be careful when addressing service users; whilst friendly teasing/ name-calling may be acceptable among friends; this is not the case when talking to service users.

**Set and maintain boundaries:** While developing good and friendly working relationships, outreach workers should remember that a service user is not a personal friend. Overstepping work relationships can compromise the service user, the project worker, and the service. Therefore, staff should not

- Fraternise, socialise, have sex/relationships with, buy sex from, or buy drugs/alcohol for or from key population members who are their service users.
- Buy, sell, exchange, receive, lend, or borrow money, goods, or services to/from service users nor buy goods from 'sellers' (who sell stolen goods, such as clothes, make-up, sunglasses).
- Infringe the law.

Giving or receiving gifts can affect the power balances of relationships. Implementing partners/ programme heads should agree on how this should be dealt with; be aware of the power relationship between workers and service users, and develop professional relationships accordingly.

**Emotional safety:** Implementing partners should ensure the emotional and mental well-being of outreach workers. There should be procedures to allow them to express how they feel and deal with issues that arise (support supervision). Projects need to be aware of vicarious trauma and ensure that there are procedures for serious events such as the rape, murder, or death of service users. This should include procedures for supporting staff as well as arrangements for additional support for service users.

Maintaining emotional boundaries is essential. Empathy will enable an outreach worker to understand a service user's perspective and build rapport. However, outreach workers should be careful not to over-identify or strive to 'fit in'. It is vital to be clear about role, limits, policies, and procedures. Outreach workers should remember the difference between empathising and identifying.

When a delicate situation occurs and the outreach worker training or code of practice does not help in deciding what action to take, the outreach staff should call the programme manager for advice. If managerial support cannot be obtained, outreach staff should adhere to the golden rule: if in doubt, get out.

Outreach staff should be encouraged to talk openly about boundary issues, to use supervision and team

meetings to explore personal issues about service users and to challenge and support each other as appropriate. Counselling should also be available for all staff.

Staff must NEVER be under the influence of drugs/alcohol while on duty. Problematic drug/alcohol use by staff can have an adverse effect on the service. Besides breaking the law, the use of illegal drugs by outreach staff could seriously affect credibility with actual and potential service users, funders, and the general public. Consequently, discussing current drug use with work colleagues or service users during working hours or bringing illegal substances to work should result in disciplinary action.

If service users have complaints, criticisms, disagreements, or comments about the service, they should be advised to contact the programme manager and refer to the organisation's complaints procedure. If the complaint relates to the manager, this should be raised with the next line of authority or the organisation's governing body, if it exists. In order to protect the interests of service users, and the organization as a whole, it is the responsibility of every individual within the organization to ensure that inappropriate or unprofessional behaviour is notified to the project manager or the next line of authority at the earliest opportunity.

## 2.5 PWID Outreach

Services targeting the general population are not always sensitive towards people who use drugs. Because drug use is generally illegal, many drug users are afraid to come for services. When planning interventions for people who use drugs, it is important to address these fears by creating a safe environment and using a non-judgmental and supportive approach. It is important to ensure that programme services are low threshold, accessible, and responsive to the needs of people who use drugs, both women and men. Although it is not always easy to provide outreach services in a safe environment, it is essential to treat people using drugs in a friendly and respectful manner.

A fixed site is a specific place with a caring and friendly environment, where people who use drugs can receive injection equipment and condoms, dispose of used equipment, and get support and information from project staff.

Fixed sites can be drop-in centres, community centres (chill-out facilities), pharmacies, or specialised voluntary counselling and testing (VCT) centres, which are closely linked to outreach services in the area.

Location, access, and environment should be the first concerns when establishing a fixed site. It needs to be convenient for clients, as it is vital that drug users feel comfortable about visiting the site. Needle and syringe programmes at fixed sites are low threshold—they offer a 'safe place' to receive clean needles and syringes, condoms, and information about HIV, and referral to other services in a friendly atmosphere. They should be responsive to the needs of drug users from different groups and located in places where they live or spend time. They should have opening hours that match the daily patterns of the local drug-using community.

Easy access allows for quick-stop service for those drug users who may be cautious of greater interaction and education. A fixed site could be located close to or within a neighbourhood where drug-buying and selling are common, or in neighbourhoods with high concentrations of people who use drugs. It is good when the location for the fixed site is relatively discreet, so that people who use drugs can visit it without being noticed by the police or general public.

It can be helpful to offer additional services at a fixed site, such as voluntary counselling and testing for HIV and other blood-borne viruses, legal services, health care and health services for TB and STIs, family or parental support services, and overdose prevention and management.

### Distributing Commodities through Outreach

The basic package of commodities provided through outreach can include sterile syringes, condoms, and alcohol swabs. But depending on risk practices and the needs of people who use drugs, outreach staff can also distribute needles, sterile injecting water, cookers or spoons, tourniquets, and filters. Organisations may also provide bandages, cotton wool, disinfectants, bleach solution, vitamins, painkillers like aspirin, ointments for treating wounds and bacterial infections, or drugs to prevent an overdose (for example, Naloxone).

When providing sterile needles and syringes in the quantities demanded by people who use drugs, outreach staff should encourage clients to return them after use, but returning used equipment should not be a condition for receiving clean equipment.

When outreach workers provide services to people using non-injecting drugs, the package of commodities can include foil, individual stems, and pipes for smoking and inhaling drugs. It is also possible to teach people how to make their own equipment for smoking and inhaling.

If the outreach involves exchange of needles and syringes, the outreach workers need a puncture-resistant container. If this is not available, they can use empty plastic water bottles to collect used needles and syringes.

Plastic bottles can also be used for water purification in settings where fresh and clean running water is not easily available. Giving advice to rinse hands and clean injection sites before injecting, outreach workers can supply people with clean water or, if that is not possible, explain how to disinfect water by exposing it in clean plastic bottles to direct sunlight for six hours, keeping the bottles outside, preferably on a rooftop.

The following services can be provided to people who use drugs and their partners through outreach:

- relevant and credible education and information regarding HIV, hepatitis B and C, sexually transmitted infections (STIs), health, and reduction of risks—both injecting-related risks and sexual risks
- provision of clean injecting equipment, and collection of used equipment
- relevant and credible education and information about ART, drug dependency treatment, and other treatment services, such as for tuberculosis (TB) or treatment of opportunistic infections
- counselling for mental health, drug dependency, access to legal aid, sexual health, relationships, and family planning
- information on access to detoxification, rehabilitation, and care and support services
- referral to health, welfare, and legal services
- self-help groups, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)
- overdose prevention, including Naloxone administration

If properly trained, outreach workers can be a reliable source of harm reduction information and services, not only to people who use drugs and their relatives but also to others, such as people from the local community or neighbourhood where outreach takes place, the police, and representatives from agencies providing services to drug users. Outreach workers can be opinion-makers and raise awareness of HIV and drug use among communities.

**Low-threshold services** are

- responsive to the lifestyle of people using drugs
- operating at a convenient time and in a suitable place
- confidential
- imposing few rules on clients
- free of charge

## 2.6

### BCC IS BASED ON BEHAVIOUR CHANGE THEORIES AND MODELS

BCC has its origins from and draws on over 70 behaviour change theories and models, including the Health Belief Model, Theory of Reasoned Action, Trans-Theoretical Model, Stages of Change Theory, Steps in Behaviour Change, and, Diffusion of Innovations. These theories and models help in understanding what influences behaviour adoption or maintenance and contribute to the planning, implementation, and evaluation of evidence-informed BCC interventions.

*The Health Belief Model* stipulates that a person's health-related behaviour depends on the person's perception of four critical areas: the severity of a potential illness, the person's susceptibility to that illness, benefits of taking preventive action, and the barriers to taking that action. The model incorporates actions as important elements in eliciting or maintaining patterns of behaviour (for example, setting an alarm to remind oneself to take medicine).

*Theory of Reasoned Action* states that an individual's behaviour is primarily determined by the person's intention to perform that behaviour. This intention is determined by two important factors: the person's attitude toward the behaviour (i.e., beliefs about the outcomes of the behaviour and the value of these outcomes) and the influence of the person's social environment or subjective norm (i.e., beliefs about what other people think the person should do, as well as the person's motivation to comply with the opinions of others).

*Stages of Change* theory has been conceptualized as a five-stage process or continuum related to a person's readiness to change: (i) pre-contemplation, (ii) contemplation, (iii) preparation, (iv) action, and (v) maintenance (illustrated in Figure 8). People progress through these stages at varying rates, often moving back and forth along the continuum a number of times before attaining the goal of maintenance.

The stages of change are better described as spiralling than as linear. In this model, people use different processes of change as they move from one stage of change to another. Efficient self-change depends on doing the right thing (processes) at the right time (stages). According to this theory, tailoring interventions to match a person's readiness or stage of change is essential. For example, for people who are not yet contemplating becoming more active, encouraging a step-by-step movement along the continuum of change may be more effective than encouraging them to move directly into action.

### Elements of Successful BCC interventions

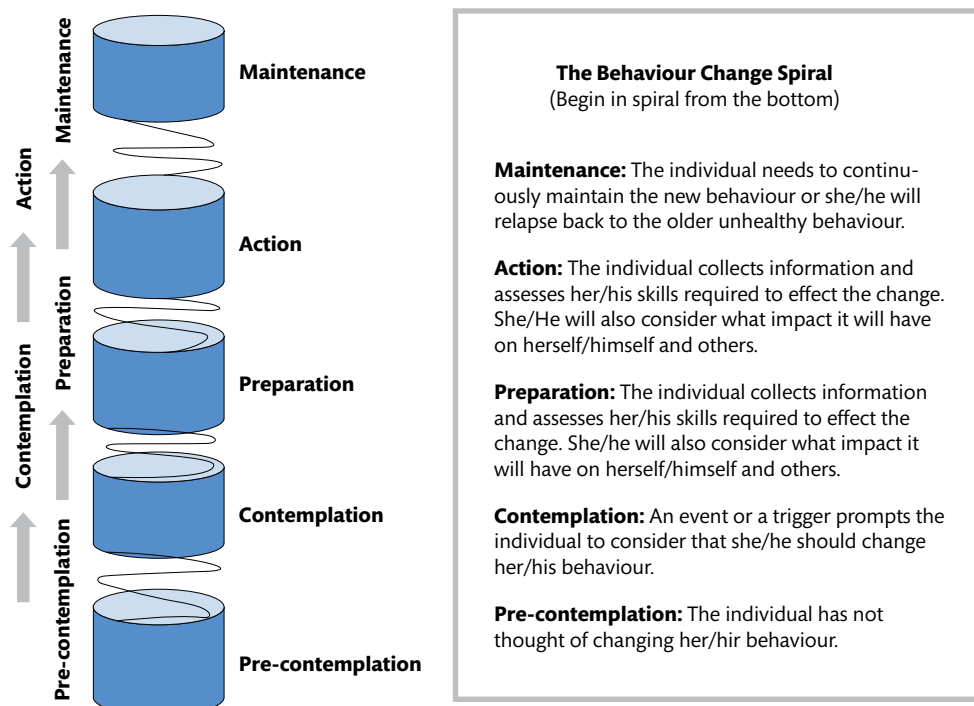
Before designing a BCC intervention, it is important to be clear about exactly whose behaviour is to be influenced and which aspect of their behaviour should be the focus for change. Communities are made up of different groups with different risk and vulnerability factors. Even within the same broad group, there may be subgroups with distinct characteristics. Different target groups will require different approaches. Therefore, when making decisions about which target groups and which factors to address, it is necessary to consider

- which target groups are most vulnerable
- which risk / vulnerability factors are most important
- which factors may be related to the impact of conflict and displacement
- which target groups and risk / vulnerability factors the community wants to address
- what could be motivators for behaviour change
- what could be barriers to behaviour change
- what type of messages will be meaningful to each target group
- which communication media would best reach the target group
- which services/resources are accessible to the target group
- which target groups and risk / vulnerability factors are feasible in terms of expertise, resources, and time

## Behaviour Change Communication Programme Implementation

A successful BCC programme requires careful research and thorough pre-testing of communication materials. It is important not to underestimate the effort required to carry out good-quality behavioural research that yields accurate and useful findings.

FIGURE 8: **Behaviour Change Spiral**



In 2013, NASCOP finalized a communication strategy for key populations, which provides a comprehensive outline of BCC/IEC/IPC approaches in the Kenyan context. For the purposes of these guidelines, this section provides highlights of the contents therein.

Key population interventions aim to change their risky behaviours. However, experience has shown that providing people with information and telling them how they should behave ('teaching' them) through information, education, and communication (IEC) materials is not enough to bring about behaviour change. While providing information to help people to make a personal decision is a necessary part of behaviour change, behaviour change communication recognizes that behaviour change also requires a supportive environment. Additionally, BCC moves beyond IEC messages to encourage analytical thinking and problem-solving among individuals and small groups of key populations. This enables them to arrive at and act on locally appropriate solutions to overcome their barriers to HIV/STI risk reduction, through peer educator-facilitated, dialogue-based, interpersonal communication (described in the next section).

Behaviour change communication uses a science-based approach to communication that involves behavioural sciences, social learning, and persuasion theory to achieve realistic targets.

The objectives of BCC are to reduce high-risk behaviours and promote health-seeking behaviours among key populations. BCC also seeks to influence healthcare providers to deliver quality, non-discriminatory services to key populations and those living with HIV.

BCC messages should aim to

- create awareness about the importance of using condoms for every penetrative sexual act—vaginal and anal—with clients or with regular partners
- create awareness about utilising the services for STIs, including the importance of regular screening, as well as other services, such as ART and partner disclosure
- create demand for services (e.g., condoms and STI and allied health services)

Behaviour change is a goal; individuals need to move through several stages and steps before they change their behaviour. The following should be considered when planning or implementing a behaviour change campaign:

- Not all individuals go through the same steps of the process in the same order, speed or time.
- Individuals at different steps require different messages and sometimes different approaches.
- It is important to know what stage the individual is in before beginning a communication process.
- As knowledge and approval reach high levels, the emphasis of BCC must shift to advanced measures such as
  - ▶ identifying cues for action
  - ▶ maximizing access and quality of services
  - ▶ identifying and removing barriers to change
  - ▶ creating opportunities for increased peer advocacy

## Key Aspects of BCC

- It involves negotiation with the individual or community for behaviour change. This negotiation happens at all levels, involves several people, and ultimately involves negotiation with 'Self' to practice desired behaviour.
- Grounded in gender sensitive principles, BCC uses dialogue, messages, persuasion, and interpersonal and group communication as a means of exchanging information, ideas, skills, and values aimed at bringing about behaviour change or adoption of safe behaviour.
- It places emphasis on audience involvement and participation throughout the BCC process and recognises that behaviour change is as much a societal process as it is an individual decision making one.
- It takes cognizance of the crucial role played by the environment to capture attention, interest, and, most importantly, emotions which make learning and change a pleasurable experience.
- It focuses on the sustainability of communication messages and strategies.
- On its own, BCC is not enough:
  - ▶ Social norms and public policies influence behaviour change. Structural changes must simultaneously happen.
  - ▶ It needs to be used in complementarity/conjunction with other prevention strategies/approaches, such as STI treatment, condom and lubricant distribution, and the creation of an enabling environment.

## Main Methods of BCC

- Interpersonal
  - ▶ Interpersonal communication is the preferred choice for targeted interventions as it involves sustained contact and communication with the sub-population.
- Mass Media
  - ▶ Can be used to support interpersonal communication efforts and the creation of an enabling environment

## The Dialogue-Based IPC Framework

Interpersonal communication (a key component of BCC) moves beyond messages and through face-to-face interaction, dialogue, and critical reflection; and helps key populations identify barriers to STI/HIV risk reduction, analyse these barriers, and plan ways to address them.

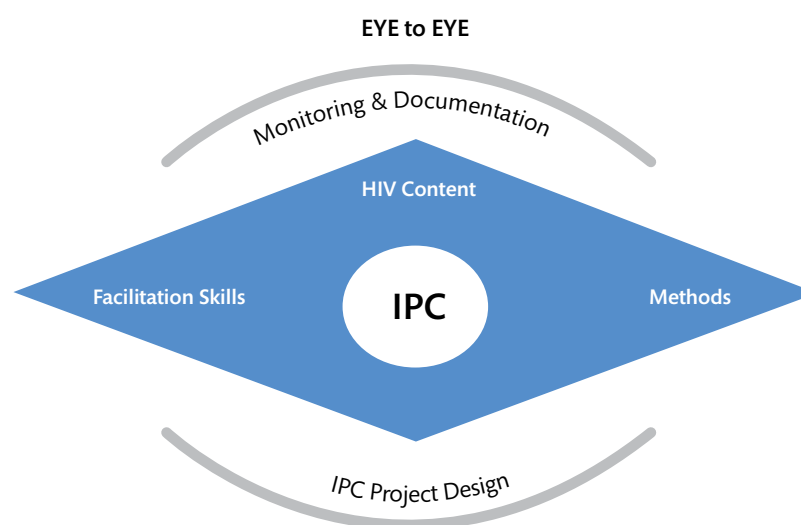
Key characteristics of interpersonal communication are that it

- Uses the principle of outreach
- Establishes personal relationships

- Builds group consciousness
- Encourages dialogue and feedback
- Elicits community initiatives and participation
- Links to community events

Interpersonal communication can be facilitated by peer educators or outreach workers who closely identify with the community.

FIGURE 9: **IPC Framework**



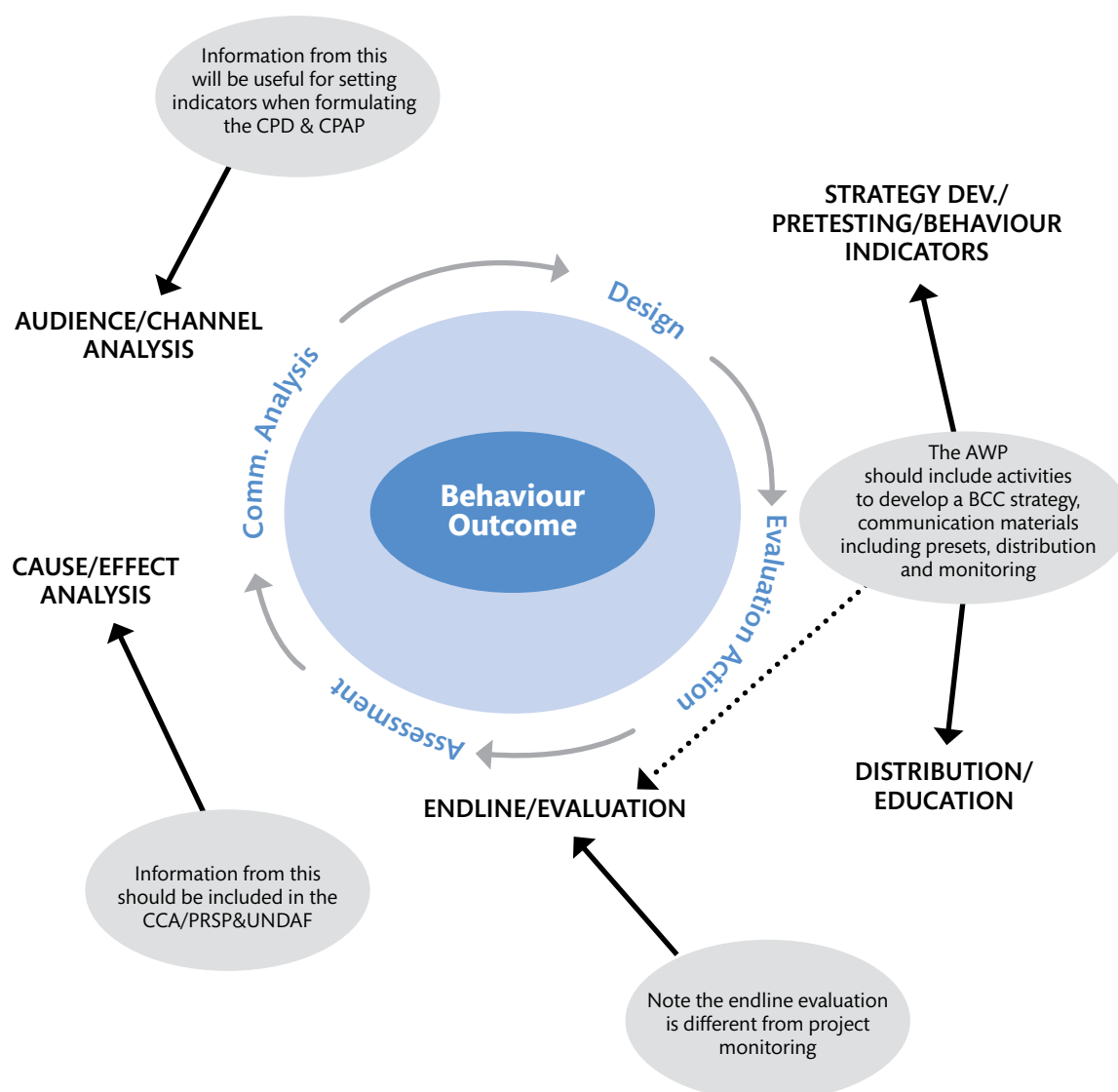
IPC framework for HIV/STI risk reduction with core HRGs

As represented in Figure 9, the IPC framework includes the four cornerstones of IPC—HIV/STI content, methods, facilitation skills, and values and attitudes—as well as the two essential aspects of creating successful IPC programmes: IPC project design and on-going monitoring and documentation.

- **HIV/STI content** covers the barriers to risk reduction for key populations, including social and environmental factors, as well as epidemiological issues.
- **Methods** are processes used to stimulate IPC and are selected to make the best possible use of each IPC opportunity.
- **Facilitation skills** focus on ways to promote real dialogue, discussion, and debate rather than merely giving messages.
- **Attitudes and values** deal with the appropriate attitudes and values for working with key populations and underlie all capacity areas essential to an organisation implementing IPC projects.
- **Project design** looks at how the project is organised to be both efficient and effective.
- **Monitoring and documentation** are used to improve project processes and to share learning within and beyond the IPC project.

These components of the IPC framework complement and reinforce each other, and together enhance the sustainability, quality, integrity, and impact of interventions.

FIGURE 10: The ACADAE Communication Process IPC Framework



#### Illustrative example of types of BCC/IPC materials

|           |               |              |            |
|-----------|---------------|--------------|------------|
| Leaflets  | Flip charts   | Au dio tapes | Comics     |
| Posters   | Flip books    | Films        | Puppets    |
| Pamphlets | Cinema slides | Video        | Theatre    |
| Fliers    | Exhibitions   | Games        | Local arts |

### The ACADAE Planning Process for BCC

An effective BCC intervention follows the sequential steps of **assessment, communication analysis, design and development, action, and evaluation**, referred to as the 'ACADAE' process (Figure 10). The process is quite universal and is applicable to all models for the development of a BCC intervention.<sup>4</sup>

<sup>4</sup> Planning Behaviour Change Communication (BCC) Interventions: A Practical Handbook, UNFPA (2006)

## Assessment

Assessments of critical societal and individual behaviours that impact on reproductive health and public health issues such as HIV/AIDS should be undertaken and incorporated in strategic response frameworks at national and county level. National level frameworks should ideally include information on populations' health seeking and health risk behaviours beside socio-economic and social infrastructural analysis. The information should be evidence-based, using both empirical and qualitative data to provide information on what people do, behaviour prevalence, and why they do it, and to identify influencers of such behaviours and practices. It should provide answers to questions such as, 'What is the behaviour problem?' and 'Why are some people behaving this way?' A problem cause and effect analysis could provide indication of the immediate, underlying and root causes for the problem. The frameworks should be designed, taking into consideration the cultural, gender elements and human rights-based approach to programming. This includes the stages of behaviour adoption or change of individuals/groups so as to cultivate skills needed to enable and sustain change.

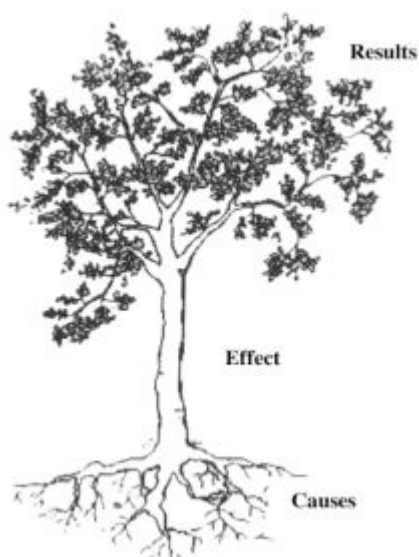
The planning of an effective BCC intervention strategy for key populations may require detailed information that is not normally available in national-level documents and may warrant the undertaking of a separate survey to collect specific data such as the level of knowledge, attitudes, and behaviours of the intended population groups. The situation analysis for BCC interventions should also differentiate between behavioural and non-behavioural causes of the problem(s) identified.

A BCC intervention requires thorough analysis of the identified problem behaviours, the context in which the problem behaviours exist, and an in-depth analysis of the people with whom implementing partners need to communicate. The challenge is to collect not only data that inform about problematic behaviours but also data and information on factors that are known to influence behaviours.

## Analysing a Problem's Causes and Effects

The solution to a problem begins with an in-depth analysis of the causes and effects created by the problem. This analysis can be done through the use of a cause/effect problem tree (Figure 11). A problem can be due to behavioural or non-behavioural causes.

FIGURE 11: **Cause, Effect, and Result Tree**



In BCC interventions, we are concerned with identifying behaviour problems that communication can influence and change. Non-behavioural problems, such as the absence or lack of a health clinic or hospital, cannot be addressed through communication intervention alone but have to be solved by appropriate advocacy and capacity-building programmes.

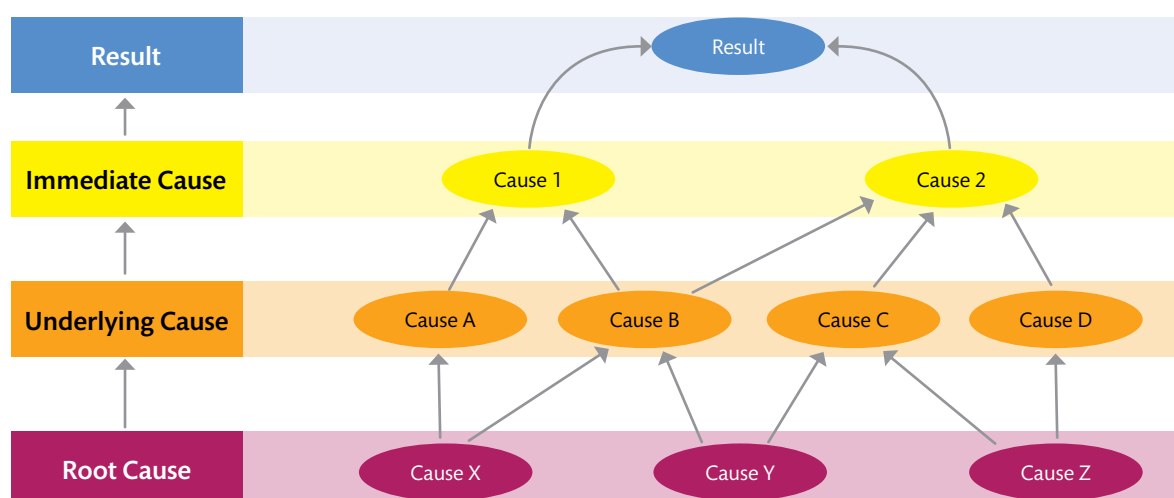
A problem tree (right) is a good analytical tool.

A problem can be the result of one or more immediate causes which may or may not be behaviour related. Each of these causes may be due to several underlying causes that in turn are due to some basic, structural, or root causes forming a results-chain of causes and effects. Causes are usually inter-related. An illustration of a problem tree and an example of the different levels of behavioural and non-behavioural causes that finally culminate in a particular result can be seen below.

FIGURE 12: **Causes & Effects Results Chain (Tabulated)**

| Illustrative Example - Result: FSW Turning HIV Positive |                                                                                           |                                                                                             |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Causes                                                  | Effects                                                                                   |                                                                                             |
|                                                         | Behaviour Related                                                                         | Non-behaviour Related                                                                       |
| Immediate (e.g., status)                                | → • Condom was not used consistently by the FSW with her clients                          | • Condom breakage/ slippage<br>• Non availability of lubricants                             |
| Underlying (e.g., access, practices, services)          | → • Recurrent STIs.<br>• Not going for routine health check-ups and internal examinations | ↑ • Lack of available trained health staff<br>• Poor referral system<br>• No peer education |
| Root (e.g., society, policies, resources, geography)    | → • Stigma and discrimination<br>• Illegality around sex work                             | ↑ • Poverty<br>• High illiteracy rate                                                       |

FIGURE 13: **The Results Chain**



### Problem Analysis

The problem analysis may begin with the question, 'What did the intended audience do that resulted in the situation?' For example, to enquire into the female sex worker who turned HIV positive, the answer to the question may be that the immediate cause was a non-use of a condom with clients. The underlying cause could be that the woman did not consistently use condoms because she was irregular for her health screening and internal examinations and counselling. The root cause could have been that she avoided medical exams and counselling because of stigma and discrimination around sex work and the illegal nature of sex work.

### Behaviour Analysis

Having identified the problem behaviours, another important step in the **ACADAE** process of planning a BCC intervention is to conduct a **behaviour analysis** to identify barriers to desired behaviours and factors that encourage certain behaviours. Behaviour analysis seeks answers to the question as to why people behave the way they do. Health outcomes of people depend on their health-seeking and health-practice behaviours. The maintenance of good health requires people to practice certain desired behaviour(s) and/or maintain positive behaviours.

| Problem Behaviour                                                            | Consequence                                                                      | Desired Behaviour                                                                      | Barriers to Desired Behaviour                                                                                                                      | Factors Encouraging Desired Behaviour                                                                                                                                |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Here, list and / or identify the behaviour problem of each 'target' or group | Here, list the consequences of the specific behaviour(s) of each target or group | Here, list what would be the desirable or positive behaviour(s) of the target or group | Here, list what could be the barriers for the desirable behaviour(s)                                                                               | Here, list all the factors that can influence and encourage performing the desired behaviour(s)                                                                      |
| Sample questions for each cell                                               |                                                                                  |                                                                                        |                                                                                                                                                    |                                                                                                                                                                      |
| Who is the primary target?                                                   | What will happen if the person/group continues with the behaviour?               | Ideally, what should the behaviour(s) be?                                              | Who/What is preventing the person/group from 'doing the right thing'?                                                                              | Who/What can influence the behaviours?                                                                                                                               |
| Examples of answers to above questions                                       |                                                                                  |                                                                                        |                                                                                                                                                    |                                                                                                                                                                      |
| Pregnant women don't seek pre-natal care from trained health staff           | Risk of delivery complication resulting in maternal death                        | Pregnant women attend regular pre-natal check-up at local health centre                | <ul style="list-style-type: none"> <li>• Ignorance</li> <li>• Unsupportive husbands</li> <li>• Negative traditional beliefs and customs</li> </ul> | <ul style="list-style-type: none"> <li>• Supportive local leaders</li> <li>• Supportive neighbours</li> <li>• Presence of trained health staff in village</li> </ul> |

### Communication Analysis

An important step in the BCC planning process is to conduct a **Communication Analysis**. This includes identification of communication networks within the community. Health service providers will need to work with these communication networks to effect desired behaviour change or maintenance of healthy behaviours among their intended audiences.

Communication channels can include community media, such as street or community theatre, folk-media, storytelling, and artefacts. It is crucial at this stage to learn how different channels are used, by whom,

when, and for what purpose. The communication analysis also identifies the primary and secondary audiences as well as potential partners for carrying out the communication interventions.

**Communication analysis** consists of:

1. **Stakeholder analysis:** This provides an understanding of the people who can influence the programme and create an enabling environment for key populations. Stakeholders can be classified as primary and secondary stakeholders in influencing or affecting the health behaviour of the intended audience.
2. **Audience analysis:** A BCC message is targeted at specific audiences to change their behaviour(s) or to have them maintain their current positive behaviour(s). Hence it is important to identify the primary audience as well as the secondary audience. The primary audience is the person or group of people whom you want to address directly (i.e., target) with specific messages to change or modify her/his or their behaviour(s) in order to improve their health. The secondary audience is the person or group of people who can influence the primary audience to change her/his or their behaviour(s). The secondary audience is usually the supportive partner, friends/peers, relatives, and/or community leaders.
3. **Channel analysis:** Communication channels analysis must not be confused with analysis of the various media used for communication. The former examines the channels people use for communicating with each other, when they communicate, and how much time they spend communicating with each other, etc. While the mass media may reach a large audience, it may not reach the intended audience if they do not have access to the media, be it radio, television, or newspapers.
4. **Media/materials analysis:** Communication media and materials should be locally contextualized and culturally relevant to be effective. Quite often, communication channels and communication media are used interchangeably. We should avoid this.

### Design and Development

Data from previous sections on **assessment** and **communication analysis** must be incorporated into the communication strategy.

It is important to have clear BCC outcome and outputs statements and corresponding result-based indicators.

A BCC strategy has three components: i) **BCC Intervention**, ii) **Advocacy**, and iii) **Social Mobilization**. Each of these components may warrant sub-strategies of their own or they can complement each other in a larger BCC intervention strategy.

In tackling a public health issue such as prevention of HIV/AIDS, **BCC interventions** are directed at individual and societal behaviour change. For example, we know that risky behaviour, such as having many sex partners and engaging in unprotected sex, can lead to being infected with HIV. In some cases, it is the individual's choice to continue practising risky behaviour. Hence, the BCC intervention addresses an individual directly to inform, educate, and persuade her/him to change her/his sexual behaviour. Depending on the situation, social marketing may be incorporated into the BCC intervention strategy, as it can play a role in changing a person's behaviour.

**Advocacy** in a BCC intervention strategy is directed at high-level stakeholders to solicit their support at the policy and legislation levels. An example of high-level advocacy is to lobby legislatures to introduce and pass an education policy and regulations to mandate the compulsory teaching of reproductive health in schools.

**Social mobilization** can garner support for and acceptance of the BCC interventions at the community level. Social mobilization is a process of bringing together all potential partners and allies to perform a common development activity in a cost-effective manner, whereas community mobilization is a process through which action to improve health is stimulated by a community or by external stakeholders; and then planned, carried out, and evaluated by the community.

|                           |                            |
|---------------------------|----------------------------|
| <b>National Outcomes:</b> | <b>Outcome Indicators:</b> |
| <b>National Outputs:</b>  | <b>Output Indicators:</b>  |

| <b>Areas for Intervention: (e.g., a specifically targeted key population and reproductive health)</b> |                                                                                                                             |                                                             |                                                                                                                      |                                                                                                                 |                                                                                                         |
|-------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Communication Strategy</b>                                                                         | <b>Intended Audience</b>                                                                                                    |                                                             | <b>Key Existing Knowledge Attitudes &amp; Behaviours</b>                                                             | <b>Key Communication Messages</b>                                                                               | <b>Communication Channels</b>                                                                           |
| Behaviour change communication interventions                                                          | Primary                                                                                                                     | (list the main / primary person to be addressed here)       | (list the existing knowledge, attitudes, and behaviours that will affect the outputs/ outcomes in order of priority) | Keep in mind the message format, message approach, and the tone used for delivering messages                    | (List only those channels that will be the most appropriate and effective for the intended audience.    |
|                                                                                                       | Secondary                                                                                                                   | (list other people of immediate importance to the audience) |                                                                                                                      | Message design depends on the type of media it is sent through<br><br>Do not clutter posters with too much text | Keep in mind the purpose of the communication: whether it is for BCC, social mobilization, or advocacy. |
| Social mobilization                                                                                   | (list all those who can support and influence both the primary and secondary audiences)                                     |                                                             | (list existing knowledge attitudes & behaviours that will affect the outputs/ outcomes in order of priority)         |                                                                                                                 | Select the channel only after doing a communication channel                                             |
| Advocacy                                                                                              | (list all those who are in position to make decisions that affect the implementation of programme that impacts on outcomes) |                                                             | (list existing knowledge, attitudes & behaviours that will affect the outputs/ outcomes in order of priority)        |                                                                                                                 | analysis.                                                                                               |

### BCC Message Design: Concepts and Development

Development of BCC messages is one of the most important elements in programming BCC interventions. BCC messages should take into account local languages, PWID colloquial terminologies, cultural sensitivities, gender, and the stages of behaviour change the intended audience is in. Thus, design of a BCC message should be different for different intended audiences.

An important point to consider while designing BCC messages is the **message approach**. By this, we mean whether the message should be informational, persuasive, encouraging, educational, gender sensitive, or action oriented, etc.

The *educational approach* provides basic information to educate the intended audience. Such an example could be, 'The human immunodeficiency virus (HIV) can be transmitted in one of four ways. They are through a) blood transfusion, b) unprotected sexual intercourse, c) exchange of contaminated needles, and d) from a pregnant mother to her new born child. HIV cannot be transmitted through mosquito bites or by shaking the hand of an HIV-positive person.'

The *persuasive approach* attempts to persuade the intended audience to take action or change her/his behaviour. An example of such a message can be, 'Do not litter, please help to keep our city clean.'

The **language, tone, and appeal** of a message play an important part in it being accepted easily or rejected by the intended audience. Research and experience have shown that using a positive appeal rather than a negative appeal is more effective for changing behaviour.

While developing messages and communication media materials, it is very important to **pre-test** both the messages and the materials to learn if they are appropriate for the intended audiences and whether they will help achieve the desired impact.

#### Suggested guidelines for pre-testing BCC messages and materials:

- **Audience:** Use persons who are from the demographic profile of the intended audience group. We should not rely on tests done with urban audiences if the communication message(s) and materials are to be mainly used in rural areas.
- **Media:** Do not use only the script of a video to pre-test a video; make a draft version of the video and then pre-test.
- **Place:** Materials that we intend to use in somebody's home should not be tested in an office in the Ministry of Health or other official place.
- **Frequency:** If the audience is supposed to be exposed to the communication materials only once, for example through a one-time only broadcast of a radio programme, do not repeatedly re-play the tape during the pre-test, even if requested by the pre-test audience. If the material is a 30-second audio spot that will be played 10 times a day on a radio station, then it is acceptable to play it more than once during the pre-test.

## Action

Elements of a detailed BCC intervention work plan could include the following:

### Preparation:

- Recruitment
- Capacity building
- Procurement
- Planning workshops (needs assessments, consulting and involving stakeholders including target groups)
- Drafting messages and preparing media materials with participation of partners and target group/beneficiaries
- Pre-testing, revising, finalizing the production
- Organizing display venues and distribution of materials
- Training of volunteers and/or staff

### Implementation:

- Geographic coverage (national, regional/provincial or local)
- Level (macro and micro level)
- Timing (month, week/day, duration)
- Actors/players (peer, parent, health worker, journalist, artists, role model)
- Methods (performance, participatory workshop, distribution of material, video performance)
- Partnerships (funding and resources such as media, expertise and technology)

### Budget:

- Costing for various activities
- Costing for human resources
- Costing for production and distribution of materials

It would be useful to have all these details displayed in a Gantt chart so that each item, be it activity or budget or timeline, can be monitored.

Illustrative Example: **The BCC Segmentation Framework** below outlines the who, what, where, and how in the effective delivery of BCC to key populations.

| Populations                                     | Key Messages                                                                                                                           | Point of Delivery                                                                | Mode of Delivery                                                           | Placements                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Female sex workers</b>                       | Condom Use<br>HIV Testing<br>Regular Clinical Check-ups<br>HIV Basic Info.<br>Condom Negotiation<br>Crisis Management                  | Peer Educators<br>Outreach Workers<br>Clinicians<br>Counsellors<br>DIC based IEC | Peer Educators:<br>Flip Charts<br>Flash Cards<br>Pocket Books<br>Brochures | <ul style="list-style-type: none"> <li>• Flip Chart/ Flash Cards:</li> <li>• Basic of HIV</li> <li>• How to use a condom, Negotiation</li> <li>• Self Esteem, Crisis</li> <li>• Understanding STIs</li> <li>• HIV Testing and Care</li> <li>• Brochure (Takeaway):</li> <li>• How to use a condom</li> <li>• STI services and understanding STIs</li> </ul>  |
|                                                 |                                                                                                                                        |                                                                                  |                                                                            | <ul style="list-style-type: none"> <li>• Counsellor/Clinician</li> <li>• Condom demonstration</li> <li>• HIV testing and care</li> <li>• Regular clinical check-ups</li> </ul>                                                                                                                                                                               |
|                                                 |                                                                                                                                        |                                                                                  |                                                                            | DIC Based IEC<br>Posters: Importance of Condoms, Clinical Visits, Testing and Care, Interactive Games, such as Snakes and Ladders<br>Others                                                                                                                                                                                                                  |
| <b>Men and transwomen who have sex with men</b> | Condom Use<br>HIV Testing<br>Regular Clinical Check-ups<br>HIV Basic Info.<br>Condom Negotiation<br>Crisis Management<br>Lubricant Use | Peer Educators<br>Outreach Workers<br>Clinicians<br>Counsellors<br>DIC based IEC | Peer Educators:<br>Flip Charts<br>Flash Cards<br>Pocket Books<br>Brochures | <ul style="list-style-type: none"> <li>• Flip Chart / Flash Cards:</li> <li>• Basic of HIV</li> <li>• How to use a condom, Negotiation</li> <li>• Self Esteem, Crisis</li> <li>• Understanding STIs</li> <li>• HIV Testing and Care</li> <li>• Brochure (Takeaway):</li> <li>• How to use a condom</li> <li>• STI services and understanding STIs</li> </ul> |
|                                                 |                                                                                                                                        |                                                                                  |                                                                            | <ul style="list-style-type: none"> <li>• Counsellor/Clinician</li> <li>• Condom demonstration</li> <li>• HIV testing and care</li> <li>• Regular clinical check-ups</li> </ul>                                                                                                                                                                               |
|                                                 |                                                                                                                                        |                                                                                  |                                                                            | <ul style="list-style-type: none"> <li>• DIC Based IEC</li> <li>• Posters: Importance of Condoms, Clinical Visits, Testing and Care, Interactive Games, such as Snakes and Ladders</li> <li>• Others</li> <li>• MSM Website</li> <li>• Video and audio CDs</li> </ul>                                                                                        |

| Populations                    | Key Messages                                                                                                                                                                    | Point of Delivery                                                                | Mode of Delivery                                                           | Placements                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>People who inject drugs</b> | Needle Syringe Exchange<br>Preventing Abscess<br>MAT for Detox<br>HIV Testing<br>Regular Clinical Check-ups<br>HIV Basic Info.<br>Condom<br>Negotiation<br>Crisis<br>Management | Peer Educators<br>Outreach Workers<br>Clinicians<br>Counsellors<br>DIC based IEC | Peer Educators:<br>Flip Charts<br>Flash Cards<br>Pocket Books<br>Brochures | <ul style="list-style-type: none"> <li>• Flip Chart/ Flash Cards:</li> <li>• Basic of HIV</li> <li>• How to use a condom, Negotiation</li> <li>• Self Esteem, Crisis</li> <li>• Understanding STIs</li> <li>• HIV Testing and Care</li> <li>• Brochure (Takeaway):</li> <li>• How to use a condom</li> <li>• STI services and understanding STIs</li> </ul> |
|                                |                                                                                                                                                                                 |                                                                                  |                                                                            | <ul style="list-style-type: none"> <li>• Counsellor/Clinician</li> <li>• Condom demonstration</li> <li>• HIV testing and care</li> <li>• Regular clinical check-ups</li> </ul>                                                                                                                                                                              |
|                                |                                                                                                                                                                                 |                                                                                  |                                                                            | <ul style="list-style-type: none"> <li>• DIC Based IEC</li> <li>• Posters: Importance of Condoms, Clinical Visits, Testing and Care, Interactive Games, such as Snakes and Ladders</li> <li>• Others</li> </ul>                                                                                                                                             |

### Evaluation

Having defined the behaviour outcomes, outputs, and their corresponding indicators and implemented the behaviour change strategies, it is imperative to learn whether are achieving the intended changes during and at the end of the programme or project.

Evaluation of BCC interventions can be divided into two stages: a **monitoring** stage and an **evaluation** stage.

During implementation, the BCC activities need to be monitored to see if they are on the right track and on schedule so that mid-course corrections can be made, if necessary. Typical data and indicators for monitoring activities are process indicators such as the number of communication media materials produced and disseminated (posters, flip charts, TV/radio spots, etc.) or the number of training workshops conducted (TOT, peer education, etc.).

Data for measuring results at the outcome level is generated through the use of surveys during an end-line **evaluation** of the programme or project. However, unless the outcome indicators are clearly laid down at the design stage, researchers will tend to gather process indicators only and report these as outcomes. For example, to evaluate the behaviour outcome result of TOT workshops, it is not sufficient to report that X numbers of TOT workshops were held.

Monitoring indicators can generally be divided into two types; process indicators and output indicators. **Communication process indicators** measure the inputs (e.g., cash and human resources) and activities to help achieve desirable results (e.g., number of workshops conducted, the number of IEC materials produced and/or distributed). As per the principles of the results-chain discussed in an earlier section, these inputs and activities should/will yield some measurable results or outputs.

**BCC output indicators** provide information regarding the consequence of the inputs and activities. An example of a BCC output indicator is, '100% of women of childbearing age in village X know the advantages of professionally assisted delivery.'

The result described in this sample indicator could be due to health promotion activity that happened because of training given to the village health worker. The health worker's training and activity will/should contribute to the change in behaviour outcome.

A **BCC outcome indicator** could be, 'rate of child deliveries by trained health staff increased from X% to Y% by the end of a certain period.'

BCC interventions can result in changes in individuals' *knowledge, attitudes, skills, behaviours*, and even *political commitments*. Examples of BCC outcome and output results and their indicators include

- Proportion of intended audience (e.g., men, women, adolescents, sex workers, truck drivers, young men, men having sex with men) reporting having used a condom (correctly) during their last sexual intercourse increased from X% (baseline) to Y% (end line).
- Proportion of intended audience seeking HTC in the last 6 months increased from X % (baseline) to Y % (end line).

## 2.7

### HISTORY TAKING GUIDE

| History-Taking Guide for Female Sex Workers             |                                                                                                                                                                                                                                    |
|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Present illness (Presenting complaints and duration)    |                                                                                                                                                                                                                                    |
| If a vaginal discharge                                  | Itching? Odour? Colour and consistency of discharge?                                                                                                                                                                               |
| If lower abdominal pain                                 | Vaginal bleeding or discharge? Painful or difficult pregnancy of childbirth? Painful or difficult or irregular menstruation? Missed or overdue period? History of recent delivery or abortion? Painful vaginal intercourse? Fever? |
| If rectal pain or discomfort                            | Rectal bleeding or discharge? Diarrhoea? Abdominal pain or cramping? Fever?                                                                                                                                                        |
| If a genital or peri-anal ulcer                         | Site? Painful? Recurrent? Appearance? Spontaneous onset?                                                                                                                                                                           |
| If urinary symptoms                                     | Urge to pass urine, pain when passing urine, frequency, abdominal pain. Pain when passing urine? Frequency?                                                                                                                        |
| If oral or pharyngeal symptoms                          | Sore throat or ulcers?                                                                                                                                                                                                             |
| Any other symptoms<br>Discomfort                        | Warts? Lumps? Skin rashes?                                                                                                                                                                                                         |
| Medical History (Focus on reproductive and STI history) |                                                                                                                                                                                                                                    |
| Regular STI check-ups                                   | Date of last STI check-up? Medications provided?                                                                                                                                                                                   |
| Past STI                                                | Type? Dates? Any treatment and response? Results of any prior tests?                                                                                                                                                               |
| Obstetric history                                       | Pregnancies and outcomes? Date of last menstrual period?<br>Contraceptive use?                                                                                                                                                     |

|                        |                                                                                                                                                                                                                                                    |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Other illness          | Type? Dates? Any treatment and response? Results of tests?                                                                                                                                                                                         |
| Medications            | Current medication?                                                                                                                                                                                                                                |
| Drug allergies?        | Name of drugs? Type of reactions (rash, hives, etc.)                                                                                                                                                                                               |
| Drug and alcohol use?  | Types of drugs/alcohol used? Patterns and frequency of use?<br>Injection drug use? Risk minimization strategies?                                                                                                                                   |
| <b>Risk Assessment</b> |                                                                                                                                                                                                                                                    |
|                        | Duration of sex work? Number of partners in last working day/week?<br>Sites of sexual exposure (oral, vaginal, anal)? Regular partner?<br>Symptomatic partner? Condom use with paying clients? Condom use with regular partners? Partner violence? |

### History-Taking Guide for Male and Transgender Sex Workers

#### Present illness (Presenting complaints and duration)

|                                                                |                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If a urethral discharge                                        | Colour and consistency of discharge? Difficulty or pain with urination?<br>Frequency of urination?                                                                                                                                                                                                                                                 |
| If rectal pain or discomfort                                   | Rectal bleeding or discharge? Diarrhoea? Abdominal pain or cramping? Fever?                                                                                                                                                                                                                                                                        |
| If a genital or peri-anal ulcer                                | Site? Painful? Recurrent? Appearance? Spontaneous onset? Pain and swelling in the inguinal region?                                                                                                                                                                                                                                                 |
| If oral or pharyngeal symptoms                                 | Sore throat or ulcers?                                                                                                                                                                                                                                                                                                                             |
| Other Symptoms                                                 | Warts? Lumps or swelling? Skin rashes?                                                                                                                                                                                                                                                                                                             |
| <b>Medical History (Focus on reproductive and STI history)</b> |                                                                                                                                                                                                                                                                                                                                                    |
| Regular STI check-ups                                          | Date of last STI check-up? Medications provided?                                                                                                                                                                                                                                                                                                   |
| Past STI                                                       | Type? Dates? Any treatment and response? Results of any prior tests?                                                                                                                                                                                                                                                                               |
| Other illness                                                  | Type? Dates? Any treatment and response? Results of tests?                                                                                                                                                                                                                                                                                         |
| Medications                                                    | Current medication? Feminization practices (where relevant)?                                                                                                                                                                                                                                                                                       |
| Drug allergies?                                                | Name of drugs? Type of reactions (rash, hives, etc)                                                                                                                                                                                                                                                                                                |
| Drug and alcohol use?                                          | Types of drugs/alcohol used? Patterns and frequency of use?<br>Injection drug use? Risk minimization strategies?                                                                                                                                                                                                                                   |
| <b>Risk Assessment</b>                                         |                                                                                                                                                                                                                                                                                                                                                    |
|                                                                | Duration of sex work? Number of partners in last working day/ week? Types of sexual behaviour practiced (oral, anal, receptive or penetrative role)? Gender of sexual partner? Contraceptives use by female partners? Regular partner? Symptomatic partner?<br>Condom use with paying clients? Condom use with regular partners? Partner violence? |

# 2.8

## ALCOHOL ABUSE SCREENING TOOL

### The Alcohol Use Disorders Identification Test (AUDIT)<sup>1</sup>

- Read questions as written. Record answers carefully. Begin the AUDIT by saying 'Now I am going to ask you some questions about your use of alcoholic beverages during this past year.' Explain what is meant by 'alcoholic beverages' by using local examples of beer, wine, spirits, local brew, etc. Code answers in terms of 'standard drinks'. Code answers based on 'standard drinks'. Place the correct answer number in the box on the right.
- One unit of alcohol is ½ a pint average strength beer/lager or one glass of wine or a single measure of spirits. Note: A can of high strength beer or lager may contain 3-4 units

| # | Question                                                                                                                          | Answer                                                                                                                                 | Number (0-4) |
|---|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------|
| 1 | How often do you have a drink containing alcohol?                                                                                 | (0) Never [Skip to Q 9-10]<br>(1) Monthly or less<br>(2) 2 to 4 times a month<br>(3) 2 to 3 times a week<br>(4) 4 or more times a week |              |
| 2 | How many drinks containing alcohol do you have on a typical day when you are drinking?                                            | (0) 1 or 2<br>(1) 3 or 4<br>(2) 5 or 6<br>(3) 7, 8 or 9<br>(4) 10 or more                                                              |              |
| 3 | How often do you have six or more drinks on one occasion?<br><br>Skip to Q 9 and 10 if Total Score for 2 and 3 = 0                | (0) Never<br>(1) Less than monthly<br>(2) Monthly<br>(3) Weekly<br>(4) Daily or almost daily                                           |              |
| 4 | How often during the last year have you found that you were not able to stop drinking once you had started?                       | (0) Never<br>(1) Less than monthly<br>(2) Monthly<br>(3) Weekly<br>(4) Daily or almost daily                                           |              |
| 5 | How often during the last year have you failed to do what was normally expected from you because of drinking?                     | (0) Never<br>(1) Less than monthly<br>(2) Monthly<br>(3) Weekly<br>(4) Daily or almost daily                                           |              |
| 6 | How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | (0) Never<br>(1) Less than monthly<br>(2) Monthly<br>(3) Weekly<br>(4) Daily or almost daily                                           |              |
| 7 | How often during the last year have you had a feeling of guilt or remorse after drinking?                                         | (0) Never<br>(1) Less than monthly<br>(2) Monthly<br>(3) Weekly<br>(4) Daily or almost daily                                           |              |

|    |                                                                                                                                              |                                                                                              |  |
|----|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|
| 8  | How often during the last year have you been unable to remember what happened the night before because you had been drinking?                | (0) Never<br>(1) Less than monthly<br>(2) Monthly<br>(3) Weekly<br>(4) Daily or almost daily |  |
| 9  | Have you or someone else been injured as a result of your drinking?                                                                          | (0) No<br>(2) Yes, but not in the last year<br>(4) Yes, during the last year                 |  |
| 10 | Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?                  | (0) No<br>(2) Yes, but not in the last year<br>(4) Yes, during the last year                 |  |
| 11 | Record total of specific items here<br><br>If total over 8, alcohol use disorder likely. Please refer to alcohol disorder treatment programs |                                                                                              |  |

## 2.9

### DRUG ABUSE SCREENING TEST (DAST)

| Drug Abuse Screening Test (DAST) <sup>2</sup> |                                                                                                                     |        |    |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------|----|
| No                                            | Question                                                                                                            | Answer |    |
| 1                                             | Have you used drugs other than those required for medical reasons?                                                  | Yes    | No |
| 2                                             | Have you abused prescription drugs?                                                                                 | Yes    | No |
| 3                                             | Do you abuse more than one drug at a time?                                                                          | Yes    | No |
| 4                                             | Can you get through the week without using drugs (other than those required for medical reasons)?                   | Yes    | No |
| 5                                             | Are you always able to stop using drugs when you want to?                                                           | Yes    | No |
| 6                                             | Do you abuse drugs on a continuous basis?                                                                           | Yes    | No |
| 7                                             | Do you try to limit your drug use to certain situations?                                                            | Yes    | No |
| 8                                             | Have you had 'blackouts' or 'flashbacks' as a result of drug use?                                                   | Yes    | No |
| 9                                             | Do you ever feel bad about your drug abuse?                                                                         | Yes    | No |
| 10                                            | Does your spouse (or parents) ever complain about your involvement with drugs?                                      | Yes    | No |
| 11                                            | Do your friends or relatives know or suspect you abuse drugs?                                                       | Yes    | No |
| 12                                            | Has drug abuse ever created problems between you and your spouse?                                                   | Yes    | No |
| 13                                            | Has any family member ever sought help for problems related to your drug use?                                       | Yes    | No |
| 14                                            | Have you ever lost friends because of your use of drugs?                                                            | Yes    | No |
| 15                                            | Have you ever neglected your family or missed work because of your use of drugs?                                    | Yes    | No |
| 16                                            | Have you ever been in trouble at work because of drug abuse?                                                        | Yes    | No |
| 17                                            | Have you ever lost a job because of drug abuse?                                                                     | Yes    | No |
| 18                                            | Have you gotten into fights when under the influence of drugs?                                                      | Yes    | No |
| 19                                            | Have you ever been arrested because of unusual behaviour while under the influence of drugs?                        | Yes    | No |
| 20                                            | Have you ever been arrested for driving while under the influence of drugs?                                         | Yes    | No |
| 21                                            | Have you engaged in illegal activities to obtain drugs?                                                             | Yes    | No |
| 22                                            | Have you ever experience withdrawal symptoms as a result of heavy drug intake?                                      | Yes    | No |
| 23                                            | Have you had medical problems as a result of your drug use (e.g. memory, loss, hepatitis, convulsions or bleeding)? | Yes    | No |
| 24                                            | Have you ever gone to anyone for help for a drug problem?                                                           | Yes    | No |
| 25                                            | Have you ever been in hospital for medical problems related to your drug use?                                       |        |    |
| 26                                            | Have you ever gone to anyone for help for a drug problem?                                                           |        |    |
| 27                                            | Have you ever been involved in a treatment program specifically related to drug use?                                |        |    |
| 28                                            | Have you been treated as an outpatient for problems related to drug abuse?                                          |        |    |

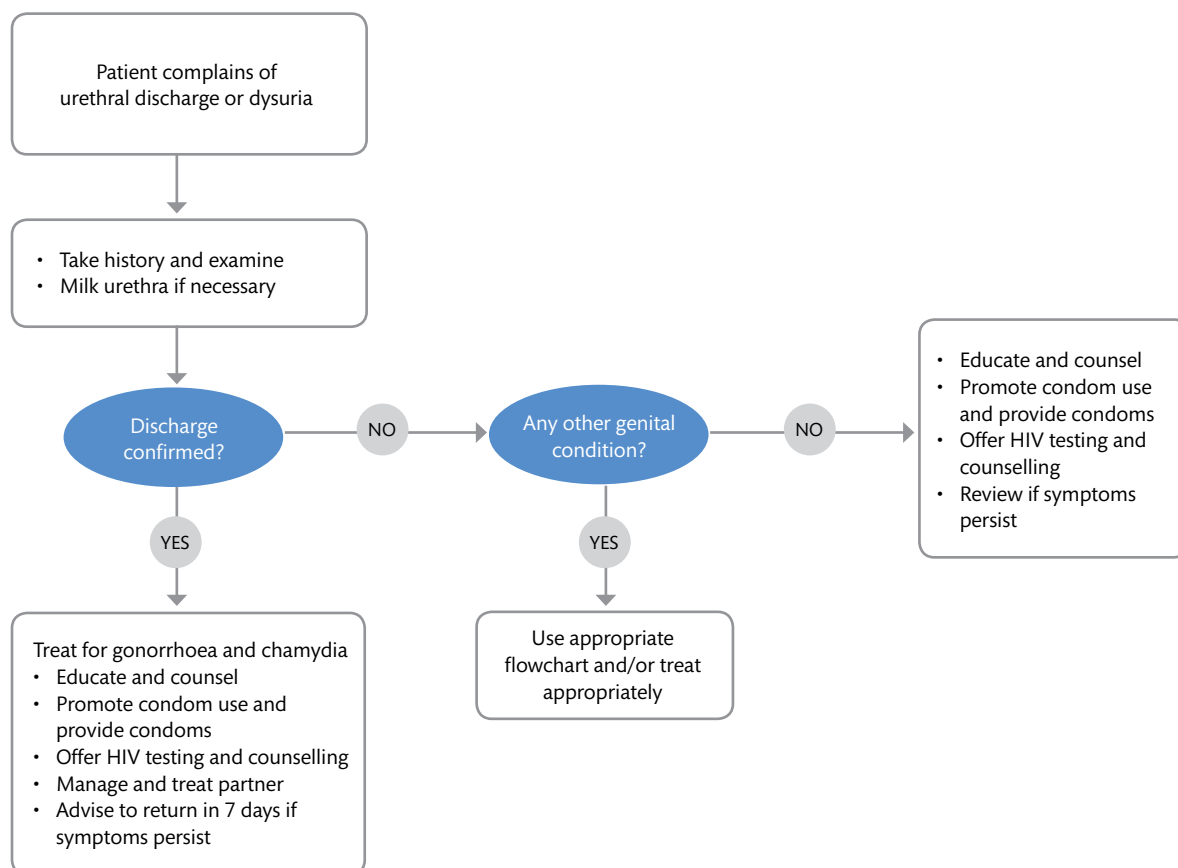
Scoring: Each item in bold = 1 point (6 or more = substance use problem and individuals need referral to treatment).

Score:

# 2.10

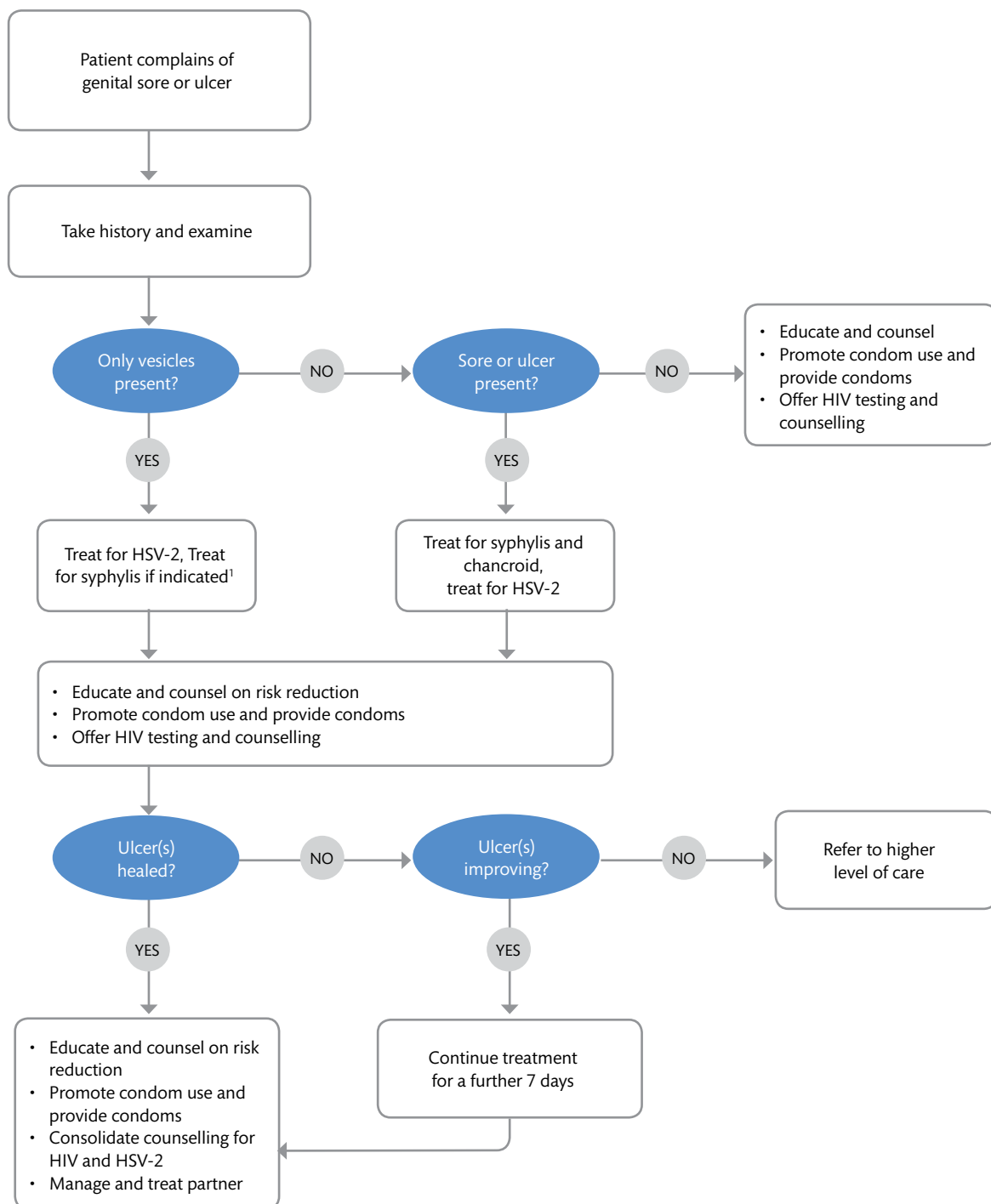
## ALGORITHMS FOR STI SYNDROMIC MANAGEMENT AMONG KEY POPULATIONS

### 2.10.1 Management Algorithm of Urethral Discharge



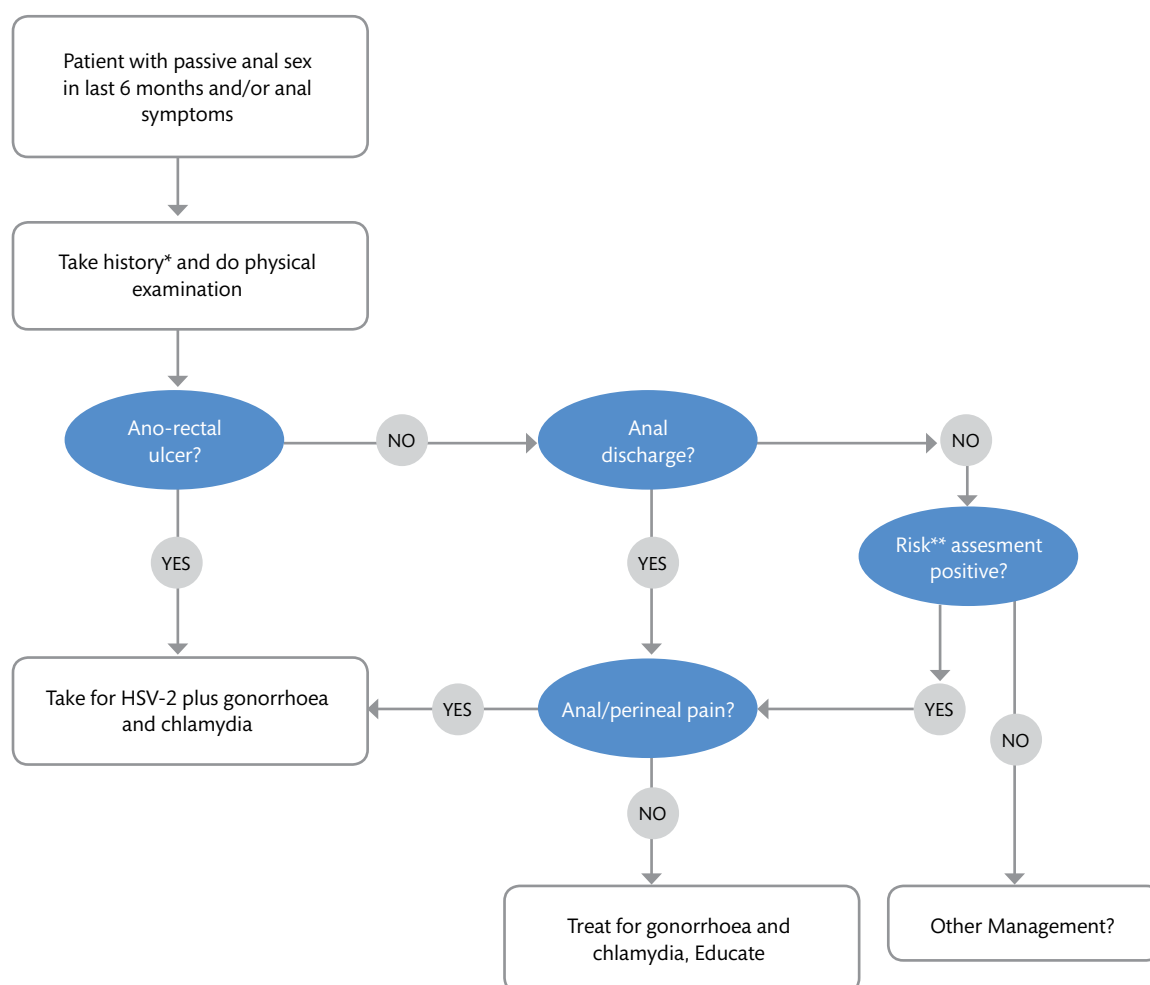
\*If microscopy is available, do Gram stain smear of urethral exudates. If no intra-cellular Gram-negative diplococci are seen, treatment for chlamydial infection only may be considered.<sup>3</sup>

## 2.10.2 Management Algorithm for Genital Ulcer Disease



<sup>1</sup> Indications for syphilis treatment: RPR positive; or patient has not been treated for syphilis recently.<sup>4</sup>

## 2.10.3 Management Algorithm for Anorectal Infections



\*History of GI conditions? Suggestive of GI emergency?

\*\*Risk: unprotected anal intercourse last 6 months, plus

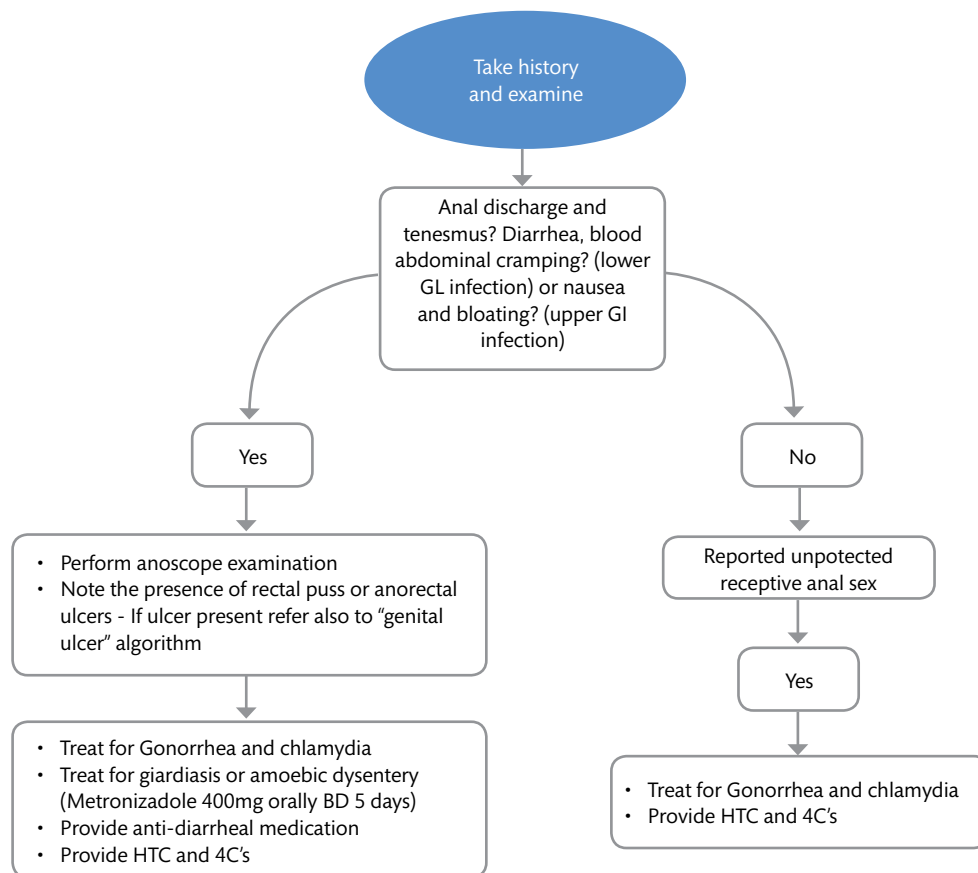
- Partner with STI; or
- Multiple partners

Follow up after 1 week. If symptoms persist:

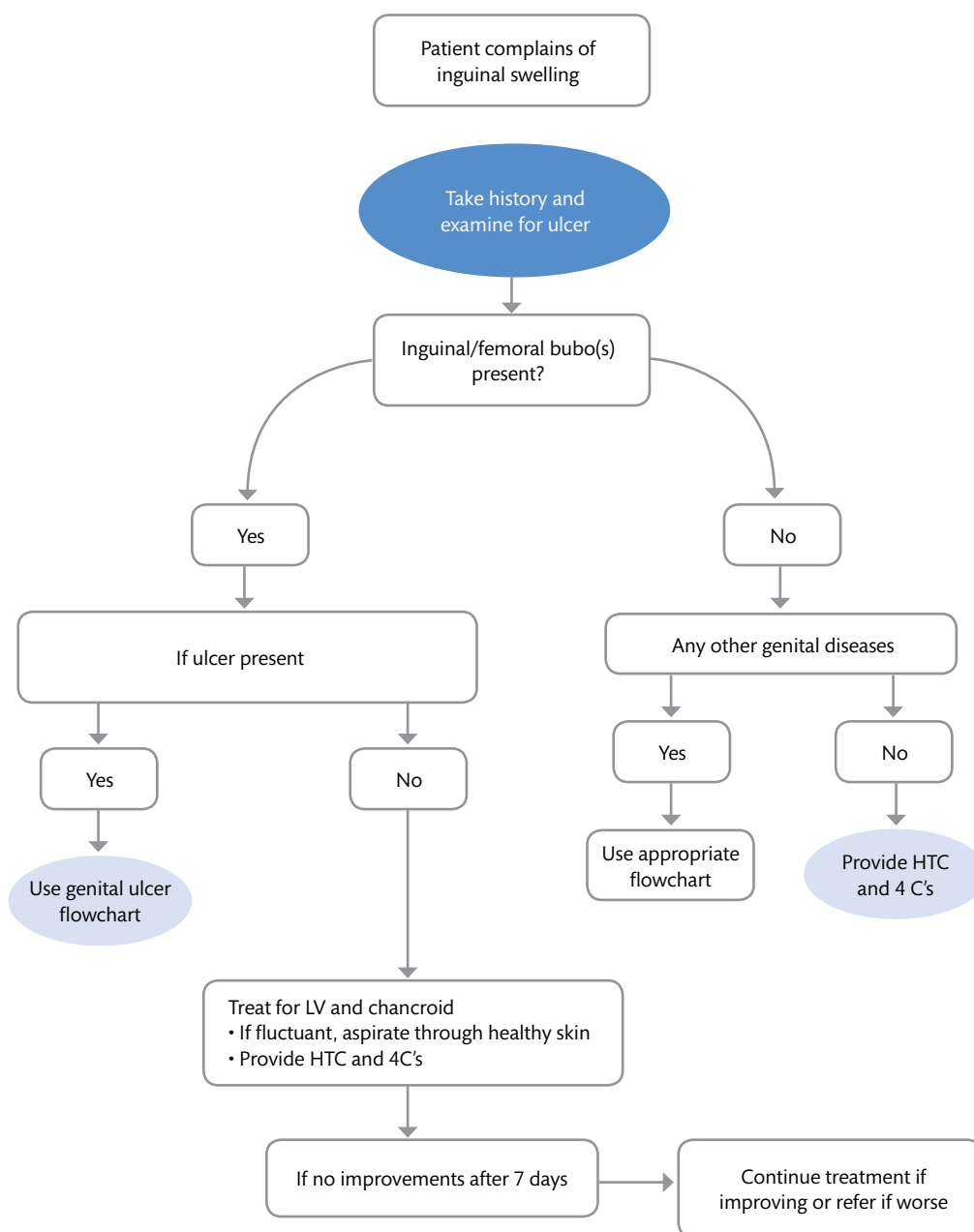
- Treat for LGV;
- Treat for HSV
- Refer

Due to its low sensitivity, microscopy is not recommended in the management of ano-rectal infections<sup>5</sup>.

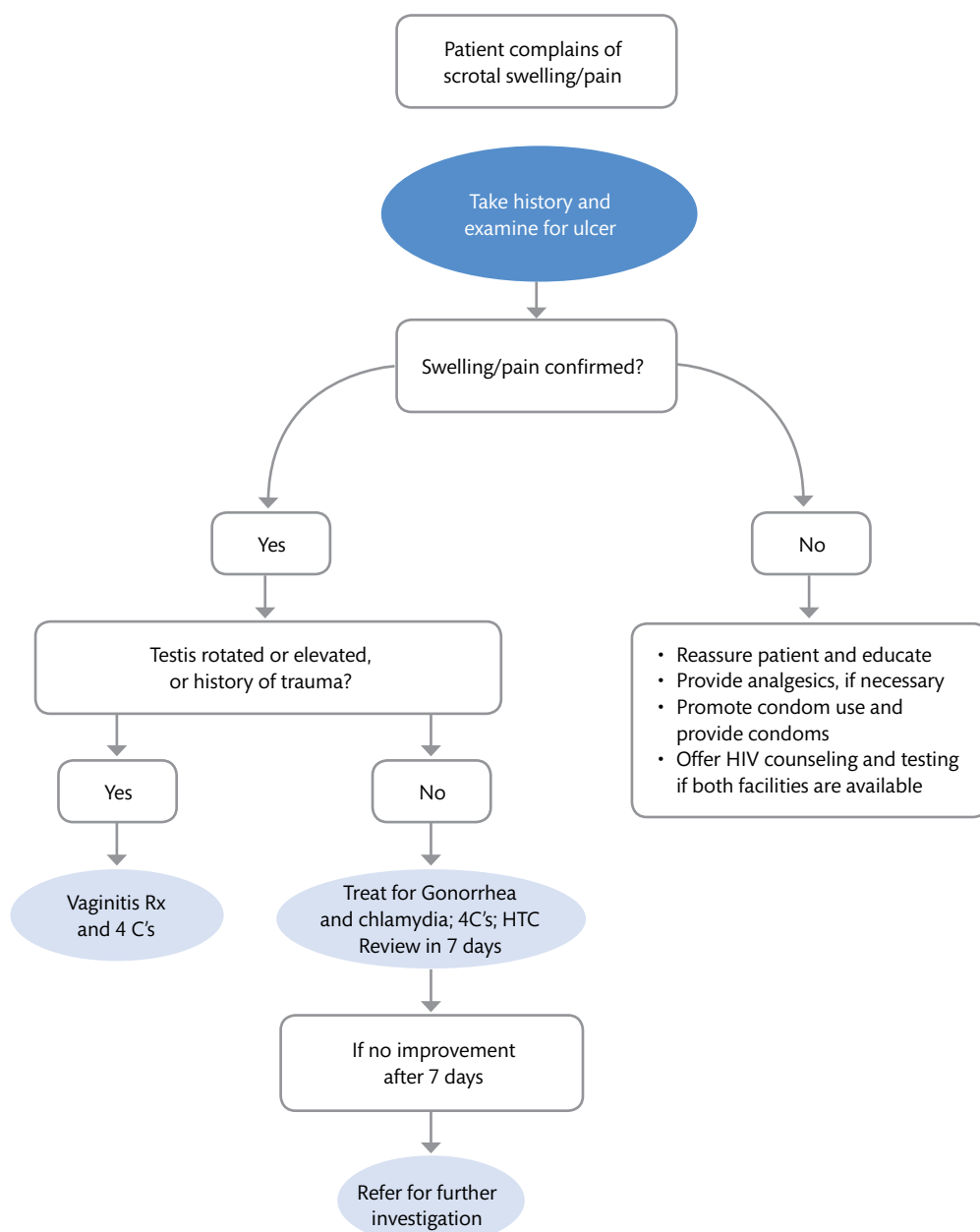
#### 2.10.4 Algorithm for Anal Discharge<sup>6</sup>



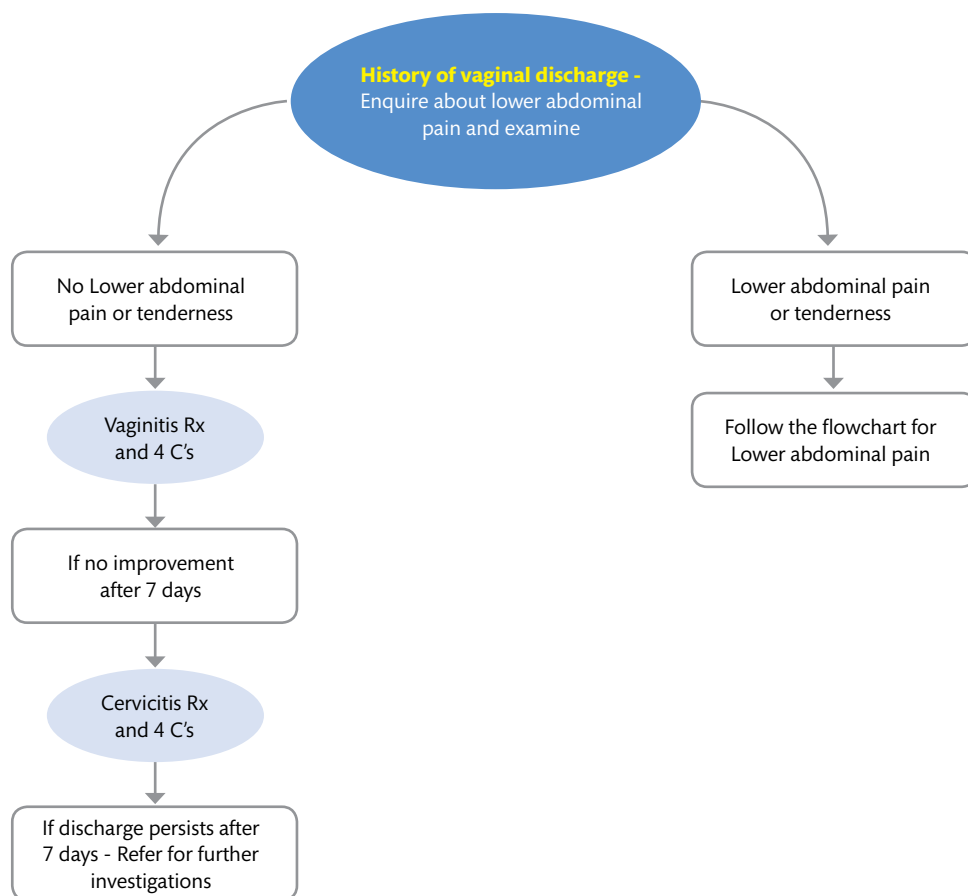
## 2.10.5 Algorithm Inguinal Bubo<sup>7</sup>



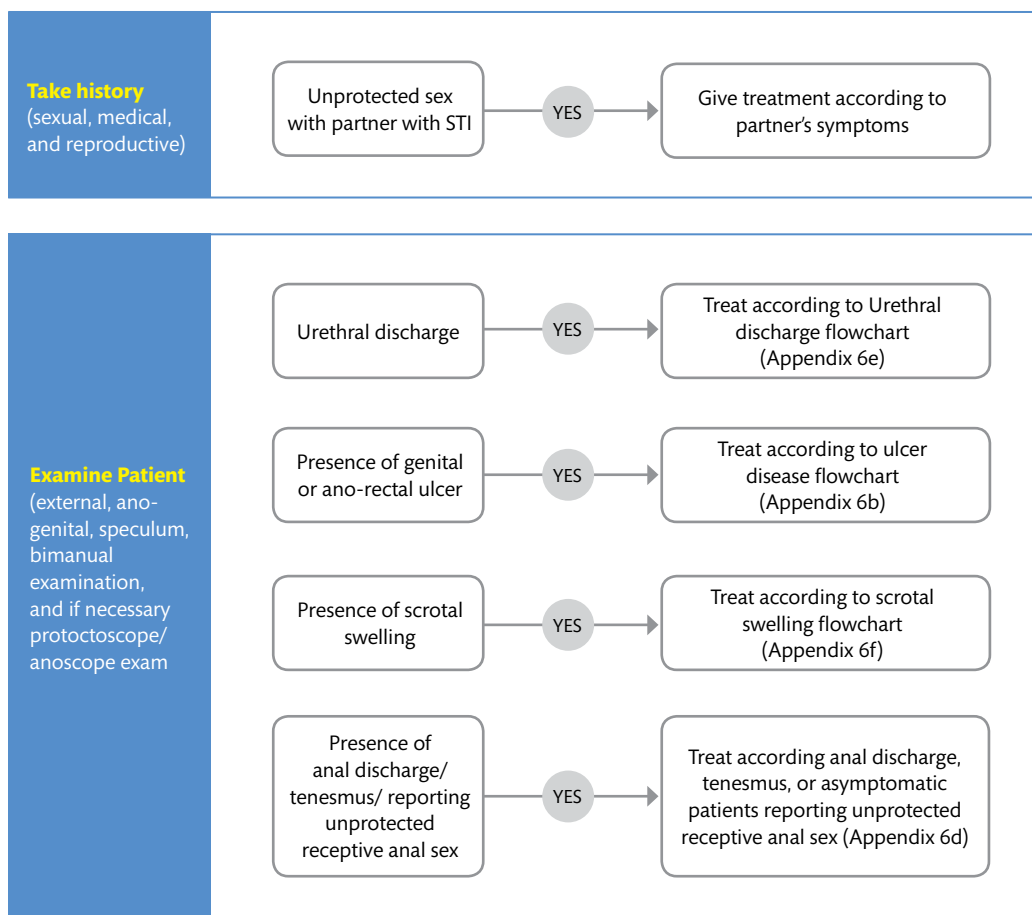
## 2.10.6 Algorithm Scrotal Swelling<sup>8</sup>



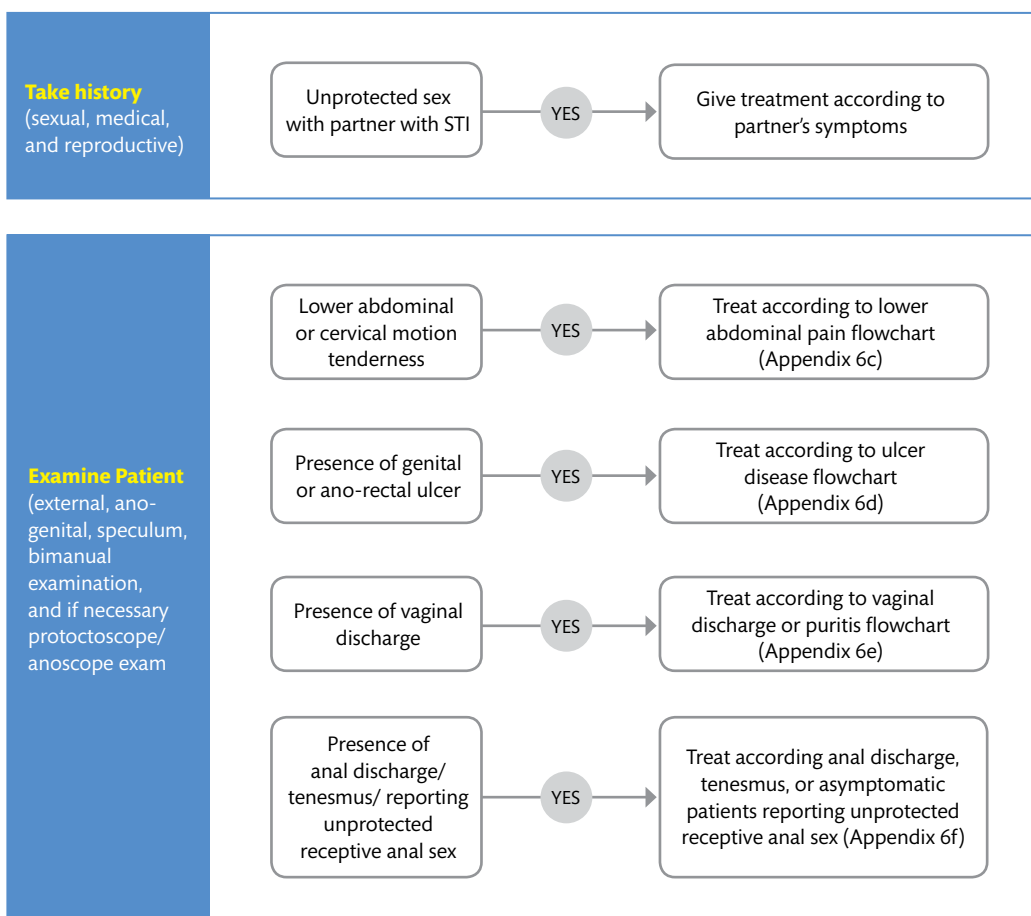
## 2.10.7 Algorithm Vaginal Discharge<sup>9</sup>



## 2.10.8 Algorithm STI - FSW<sup>10</sup>



## 2.10.8 Algorithm STI - MSM/MSW/TG<sup>11</sup>



## 2.11

### STRUCTURAL INTERVENTIONS LITERATURE REVIEW

To reduce rates of HIV among key populations, prevention programmes must address structural factors that increase people's vulnerability, such as poverty, violence, stigma and discrimination, laws and policies, and gender inequity.<sup>5</sup> Structural factors can discourage people from using HIV prevention and care services and can impede adoption of HIV-preventive behaviors. For example, fear of HIV/AIDS-related stigma and discrimination prevents key population members from seeking HIV counseling and testing<sup>6</sup> and from disclosing their status to their sexual partner.<sup>7</sup> Fear of violence stops sex workers and MSM from insisting that partners or clients use condoms.

5 Auerbach J. Transforming social structures and environments to help HIV preventions. *Health Aff.* 2009. 28(6):1655-1665. doi: 10.1377/hlthaff.28.6.1655. <http://content.healthaffairs.org/content/28/6/1655.full.pdf+html>

6 Kalichman SC and Simbaye LC. HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa. *Sex Transm Infect.* 2003. 79:442-47. doi: 10.1136/sti.79.6.442. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1744787/pdf/v079p00442.pdf>

7 Maman S and Medley A. 2004. Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes. Geneva: World Health Organization, Department of Gender and Women's Health. <http://www.who.int/gender/documents/en/genderdimensions.pdf>

Beattie et al. found that sex workers in Karnataka, India, who reported experiencing violence in the past year were significantly less likely to report condom use with clients, to have accessed the HIV intervention program, or to have ever visited the project sexual health clinic, and were more likely to have sexually transmitted infections.<sup>8</sup> In Argentina, Pando et al. found that sex workers who experienced violence had a lower rate of consistent condom use with clients, and that sex workers arrested by police had higher rates of HIV and *Treponema pallidum* infection.<sup>9</sup> Luchters et al. found that, among female sex workers in Mombasa, high-risk sexual behavior, low control, and frequent violence in relationships with emotional partners heighten FSWs' vulnerability and risk of HIV infection.<sup>10</sup> Tounkara et al. found that HIV infection among female sex workers in Benin was significantly associated with physical, sexual, and psychological violence.<sup>11</sup> Decker et al. found that physical and sexual violence were common among sex workers in Baltimore, USA, with 43% reporting past-month abuse, and that severe sexual violence from clients compromised women's condom and sexual negotiation.<sup>12</sup> A systematic review and meta-analysis of evidence by Buller et al. found that MSM who are victims of intimate partner violence are more likely to engage in substance use, suffer from depressive symptoms, be HIV-positive, and engage in unprotected anal sex.<sup>13</sup> Shaw et al. found that HIV prevalence among MSM and transgender persons in Karnataka, India, who reported sexual violence was 20%, compared to 12% among those not reporting sexual violence.<sup>14</sup> In a study of PWIDs in Vancouver, Marshall et al. found that 66% of females and 70% of males reported experiencing violence during the study period. In multivariate analyses, mental illness, frequent alcohol use, frequent crack use, homelessness, and requiring help injecting were positively associated with experiencing violence for both sexes. Women were more likely to be attacked by acquaintances, partners, and sex trade clients, while men were more likely to experience violence from strangers and the police.<sup>15</sup> In a study of PWID in Bangkok, Hayashi et al. found that respondents reported various forms of police misconduct, including false accusations, coercion of confessions, excessive use of force, and extortion of money. However, respondents were reluctant to report misconduct to the authorities in the face of social and structural barriers to seeking justice. Respondents' strategies to avoid police impeded access to health care and facilitated transitions towards the misuse of prescribed pharmaceuticals.<sup>16</sup> In a study of sex workers in Brazil, Lippman et al. found that the social context within which sex workers negotiate sexual behaviors is associated with condom use. Future efforts to prevent STI/HIV should incorporate strategies to modify the social environment.<sup>17</sup> Gurnani et al. found that stigma, discrimination, violence, harassment, and social equity issues are critical concerns of FSWs and can be addressed as part of large-scale HIV prevention programming.<sup>18</sup>

- 8 Beattie T et al. Violence against female sex workers in Karnataka state, south India: impact on health and reduction in violence following an intervention program. *BMC Public Health*. 2010. 10:476. doi:10.1186/1471-2458-10-476. <http://www.biomedcentral.com/content/pdf/1471-2458-10-476.pdf>
- 9 Pando MA et al. Violence as a barrier for HIV prevention among female sex workers in Argentina. *PLoS ONE* 2013. 8(1): e54147. Doi: 10.1371/journal.pone.0054147. <http://www.plosone.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0054147&representation=PDF>
- 10 Luchters S et al. The contribution of emotional partners to sexual risk taking and violence among female sex workers in Mombasa, Kenya: a cohort study. *PLoS ONE*. 2013. 8(8): e68855. doi:10.1371/journal.pone.0068855. <http://www.plosone.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0068855&representation=PDF>
- 11 Tounkara FK et al. Violence, condom breakage and HIV infection among female sex workers in Benin, West Africa. *Sex Transm Dis*. 2014;41(5):312-318. doi:10.1097/OLQ.0000000000000114. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4000255/pdf/nihms4370.pdf>
- 12 Decker MR et al. Violence against women in sex work and HIV risk implications differ qualitatively by perpetrator. *BMC Public Health* 2013. 13:876. doi:10.1186/1471-2458-13-876. <http://www.biomedcentral.com/content/pdf/1471-2458-13-876.pdf>
- 13 Buller AM et al. Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. *PLoS Med*. 2014. 11(3): e1001609. doi: 10.1371/journal.pmed.1001609. <http://www.plosmedicine.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.1001609&representation=PDF>
- 14 Shaw S et al. Factors associated with sexual violence against men who have sex with men and transgendered individuals in Karnataka, India. *PLoS One*. 2012; 7(3): e31705. doi: 10.1371/journal.pone.0031705. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3308942/pdf/pone.0031705.pdf>
- 15 Marshall BDL et al. Physical violence among a prospective cohort of injection drug users: a gender-focused approach. *Drug Alcohol Depend*. 2008. 97(3):237-46. doi: 10.1016/j.drugalcdep.2008.03.028. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2570226/pdf/nihms69533.pdf>
- 16 Hayashi K et al. Experiences with policing among people who inject drugs in Bangkok, Thailand: a qualitative study. *PLoS Med*. 2013. 10(12): e1001570. doi:10.1371/journal.pmed.1001570. <http://www.plosmedicine.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.1001570&representation=PDF>
- 17 Lippman S et al. Social-environmental factors and protective sexual behavior among sex workers: the Encontros intervention in Brazil. *Am J Public Health*. 2010. 100 Suppl 1:S216-23. doi: 10.2105/AJPH.2008.147462. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837432/pdf/S216.pdf>
- 18 Gurnani V et al. An integrated structural intervention to reduce vulnerability to HIV and sexually transmitted infections among female sex workers in Karnataka state, south India. *BMC Public Health*. 2011. 11:755. doi:10.1186/1471-2458-11-755. <http://www.biomedcentral.com/content/pdf/1471-2458-11-755.pdf>

# Chapter 3

## 3.1

### ILLUSTRATIVE ROLES AND RESPONSIBILITIES FOR PROJECT STAFF PROJECT COORDINATOR/ MANAGER

- Overall in-charge of all project functions
- Supervision of field and clinic activities on regular basis
- Overseeing the MIS
- Overseeing the IEC
- Development of capacity building and sustainability strategy
- Capacity building of staff and organisation
- Helping to develop programme policies and plans
- Development and monitoring of weekly work plan as per the performance indicators for Outreach Workers and counsellors
- Arrangement of weekly and monthly meetings to identify shortfalls and to evolve corrective measures/ plan of action
- Facilitating advocacy meetings and focus group discussions in the field
- Continuous analysis of the project activities as to costs incurred to ensure cost effective implementation
- Liaison with funding agency, stakeholders and oversee advocacy activities
- Clinic and field visit at least thrice weekly
- Meeting with governing body
- Monitoring and Evaluation

#### Counsellor

- Patient management, ensure partner notification, ensure follow-up of recurrent cases and one-to-one counselling of STI cases
- Pre- and post-test counselling
- Family counselling
- Community counselling programme

- Counselling patients with high risk behaviours
- Meet with community and staff
- Coordination in creating linkages/networking
- Field visit on days when not needed in clinic
- Maintenance of registers
- Recording feedback from the community

### Doctor

- Treatment (General, STI, Opportunistic Infection)
- Taking of exposure history from the patient
- Advice for investigation and referral
- Motivating the patient regarding follow-up, partner notification

### Outreach Worker (ORW)

- Lead the group of peer educators
- Trouble shoot field level outreach issues brought out by peer educators
- Field visit, awareness generation and field counselling
- Development of team work plan
- Organising advocacy meetings
- Conducting group sessions
- Development of list of target area
- Listing and meeting with local private practitioners of the target area
- Identification of peer volunteers, stakeholders, condom outlets
- Facilitating the process of capacity building of peer volunteers
- Monitoring and supervision of peer volunteers
- Meeting with the peer volunteers once a week
- Responsible for weekly report writing, record keeping, MIS
- Maintaining the stocks (medicine, condoms, IEC materials)
- Recording feedback from the community

### Peer Educators

- Rapport building with key populations
- Identify new KP and maintain relations with the KPs who are part of programme
- Dissemination of message, information about programme services
- Distribution of IEC materials
- Harm reduction commodity distribution (condoms, condom compatible lubricants, needles and syringes), including social marketing
- Motivating key populations towards STI treatment and safer sex practice
- Referral to HIV-related and other healthcare services
- Provide crisis management support to KPs
- Document the outreach work done on a daily basis.

### Accountant

- Day-to-day accounting functions
- Disbursement of salaries
- Meeting with governing body
- Preparation of appointment letters for new staff in consultation with general secretary and Project Coordinator
- Maintaining petty cash file, requisition slip, order file, quotation file, cash book, voucher file, rent and service charges file, office operating cost file, communication (telephone/T.A., etc.), bank transaction, recording daily flow chart

### Office Assistant

- Assisting the Project Coordinator in coordinating field and clinical activities
- Organising and scheduling meetings, preparing minutes and ensuring that the quarterly plan of action and budget is adhered to
- Assisting the Project Coordinator in maintaining MIS so that continuous monitoring of field activities is possible
- Aiding the team members in developing BCC materials, conducting street shows, audio-visual programmes, etc.
- Checking/verifying money receipt book and physical stock of condoms, IEC materials, Drugs

### Capacity Building of Project Staff

Trainings should be conducted for the staff on the following in alignment with national guidelines:

- Basic induction on HIV/AIDS and understanding the key population service users' vulnerabilities and the dynamics of risky behaviour.
- Skills in identifying and building rapport with key population service users and methodology of site validation.
- Outreach and micro-planning
- Programme Services—myths and misconceptions
- Structural interventions
- Commodity programming
- Programme outreach formats and reporting

Capacity building of human resources is a key aspect of interventions with key populations. Building capacity of the implementing team to bring self-change and then behaviour change among key populations in the context of HIV can be challenging. To fulfil the objectives of the interventions, efforts will need to be made to train the staff in technical knowledge and attitudinal change.

## 3.2

### QUARTERLY REPORTING KEY POPULATION PROGRAMME INDICATORS

| Key Population Programme Output Indicators for Quarterly Reporting to NASCOP |                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                      |                                              |                       |
|------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------|
|                                                                              | Indicator                                                           | Indicator Definitions                                                                                                                                                                                                         | Indicator Information Source                                                                                                                         | Indicator Benchmarks/ Performance Benchmarks | Assumptions / Remarks |
| 1                                                                            | <b>Programme Coverage</b>                                           |                                                                                                                                                                                                                               |                                                                                                                                                      |                                              |                       |
| 1.1.                                                                         | Estimated key populations in area of work                           | Total estimate of key populations in the specific geographical coverage area derived from mapping or size estimation studies. This figure should be static for the reporting year. The figure also serves as the denominator. | <ul style="list-style-type: none"> <li>• NASCOP Consensus Report</li> <li>• NGO Validation reports</li> <li>• UoM - NASCOP Mapping report</li> </ul> | None                                         |                       |
| 1.2.                                                                         | Number of key populations planned to be covered as per the contract | Total number of key populations targeted to be covered in the intervention geographical area as per contract with a funding or support agency.                                                                                | Approved Project Proposal                                                                                                                            | None                                         |                       |

|                   |                                                                                                                         |                                                                                                                                                                                                                                                                          |                                                                                                                                                      |                                            |  |
|-------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--|
| 1.3.              | Number of sites/spots through which key populations operate in the intervention geographical area                       | Total estimated number of sites/spots through which the estimated key populations (1.1) operate. This figure could be derived from the NASCOP's key populations mapping report or the projects own mapping/estimation.                                                   | <ul style="list-style-type: none"> <li>• NASCOP Consensus Report</li> <li>• NGO Validation reports</li> <li>• UoM - NASCOP Mapping report</li> </ul> | None                                       |  |
| 1.4               | Number of sites/spots through which key populations operate planned to be covered in the intervention geographical area | Total number of key population sites to be covered in the intervention geographical area as per contract with a funding or support agency.                                                                                                                               | Approved Project Proposal                                                                                                                            | None                                       |  |
| <b>2 Outreach</b> |                                                                                                                         |                                                                                                                                                                                                                                                                          |                                                                                                                                                      |                                            |  |
| 2.1               | Number of individual key populations contacted at least once in the reporting quarter                                   | Total number of individual key populations met by the project outreach team at least once through field outreach or project services in the reporting quarter. The contacts at the outreach level can be 1-1 contact or group contact at community level.                | Compiled Peer Educator / Outreach Workers reports                                                                                                    | 80 % of indicator 1.2 (Contractual target) |  |
| 2.2               | Number of new individual key populations contacted for the first time in the project during the reporting quarter       | Total number of new individual key populations contacted for the first time by the project outreach team through field outreach or project services in the reporting quarter. The contacts at the outreach level can be 1-1 contact or group contact at community level. | Compiled Peer Educator / Outreach Workers reports                                                                                                    | None                                       |  |
| 2.3               | Number of group meeting/ events conducted with key populations during the reporting quarter                             | Total number of group meetings or events conducted with key populations during the reporting quarter.                                                                                                                                                                    | Meeting Registers<br>DIC Registers                                                                                                                   | As per the Project Proposal                |  |

|            |                                                                                                                                |                                                                                                                                                                           |                                    |                                                    |  |
|------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------|--|
| 2.4        | Number of key populations who participated in the group meetings during the reporting quarter                                  | Total number of individual key populations who attended group meetings or events during the reporting quarter.                                                            | Meeting Registers<br>DIC Registers | As per the Project Proposal                        |  |
| 3 Services |                                                                                                                                |                                                                                                                                                                           |                                    |                                                    |  |
| 3.1        | Number of individual members of key populations received risk reduction counselling at least once during the reporting quarter | Total number of individual key populations who received risk reduction counselling at least once during the reporting quarter (not cumulative counselling sessions held). | Counselling Register               | 80 % of indicator 1.2 (Contractual target)         |  |
| 3.2        | Number of individual members of key populations counselled and tested for HIV during the reporting quarter                     | Cumulative number of individual key populations counselled and tested for HIV during the reporting quarter.                                                               | HTC Register                       | 80 % of indicator 1.2 (Contractual target)         |  |
| 3.3        | Number of HIV positive individual members of key populations identified during the reporting quarter                           | Cumulative number of individual key populations who tested HIV positive during the reporting quarter.                                                                     | HTC Register                       | None                                               |  |
| 3.4        | Number of key populations enrolled in care during the reporting quarter                                                        | Cumulative number of individual key populations enrolled in HIV care (e.g. cotrimoxazole prophylaxis) during the reporting quarter.                                       | CCC Register                       | 100 % of indicator 3.3 (total positive identified) |  |

|      |                                                                                             |                                                                                                                                                                                                                                                                           |                                                 |                                            |  |
|------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------|--|
| 3.5  | Number of individual key populations initiated on ART in the reporting quarter              | Cumulative number of individual key populations initiated on ART in the reporting quarter.                                                                                                                                                                                | ART Register                                    | None                                       |  |
| 3.6  | Number of Individual key populations visited a health facility during the reporting quarter | Total number of individual key populations who visited a health facility/ clinic supported by the Project / linked with the project for STI Screening during the reporting quarter.                                                                                       | Clinical Register                               | 80 % of indicator 1.2 (Contractual target) |  |
| 3.7  | Number of individual key populations treated for STIs during the reporting quarter          | Total number of individual key populations treated for STIs during the reporting quarter. Individuals are counted once irrespective of number of STIs diagnosed with and treated for.                                                                                     | Clinical Register                               | None                                       |  |
| 3.8  | Number of individual key populations provided with Post Exposure Prophylaxis                | Total number of individual key populations who reported to be exposed to HIV and provided with post-exposure prophylaxis (PEP) within 72 hours of exposure during the reporting quarter. Individuals are counted once irrespective of number of PEP episodes attended to. | PEP Register                                    | None                                       |  |
| 3.9  | Number of PWIDs treated for abscesses during the reporting quarter                          | Total number of individual key populations treated for abscesses during the reporting quarter. Individuals are counted once irrespective of number of abscess episodes treated.                                                                                           | Clinical Register<br>Abscess Recording Register | None                                       |  |
| 3.10 | Number of health camps organised for the bridge populations in the reporting quarter        | Total number of health camps organised for the bridge populations in the reporting quarter. The health camps may include provision of HIV-related as well as other general health services.                                                                               | Health Camp Register                            | As per the Project Proposal                |  |

|               |                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                 |                                             |  |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------|--|
| 3.11          | Number of individual members of the bridge populations who utilised the health camps in the reporting quarter                                        | Total number of individual members of the bridge populations who attended and utilised the health camps in the reporting quarter.                                                                                                                     | Health Camp Register<br>Clinical Register                                       | As per the Project Proposal                 |  |
| 4 Commodities |                                                                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                 |                                             |  |
| 4.1           | Number of individual members of key populations who received a condom (Male/Female) directly from the programme/project during the reporting quarter | Total number of individual key populations who received a condom (male or female) directly from a peer educator, outreach worker, or a key populations-friendly health facility, Drop-in-Centres) during the reporting quarter.                       | Peer Educator Reporting Format<br>ORW Reporting Format                          | 100 % of indicator 1.2 (Contractual target) |  |
| 4.2           | Number of male condoms distributed by the outreach staff during the reporting quarter                                                                | Total number of male condoms distributed by the outreach staff directly to the key populations (through Peer Educators, Prevention staff, Outreach workers, key populations-friendly facilities, Drop-in-Centres, etc.) during the reporting quarter. | Peer Educator Reporting Format<br>ORW Reporting Format<br>Condom Stock Register | As per the KP requirement                   |  |
| 4.3           | Number of female condoms distributed by the outreach staff during the reporting quarter                                                              | Total number of female condoms distributed by the outreach staff directly to the key populations (through Peer Educators, Prevention staff, Outreach workers, Clinics, Drop-in-Centres, etc.) during the reporting quarter.                           | Peer Educator Reporting Format<br>ORW Reporting Format<br>Condom Stock Register | As per the KP requirement                   |  |
| 4.4           | Number of condoms distributed through condom outlets during the reporting quarter                                                                    | Total number of free condoms distributed indirectly to the key populations through channels other than outreach staff (e.g. through condom dispensers, unmanned/ manned condom outlets etc.) during the reporting quarter.                            | Condom Outlet Register                                                          | None                                        |  |

|                                                  |                                                                                                                        |                                                                                                                                                                                                                                                                                                           |                                                                                         |                                            |  |
|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------|--|
| 4.5                                              | Number of water-based lubricants distributed during the reporting quarter                                              | Total number of lubes distributed in the reporting quarter through outreach, health facility or any other channel.                                                                                                                                                                                        | Peer Educator Reporting Format<br><br>ORW Reporting format<br><br>Condom Stock Register | As per the KP requirement                  |  |
| 4.6                                              | Number of needles-syringes distributed to PWIDs                                                                        | Total number of PWIDs who received syringes within the geographical intervention area during the reporting quarter (Assumption: Needles: Syringes is 1: 1).                                                                                                                                               | Peer Educator Reporting Format<br><br>ORW Reporting Format<br><br>Condom Stock Register | As per the KP requirement                  |  |
| 4.7                                              | Number of needles-syringes returned by the PWIDs to the programme during the reporting quarter                         | Total number of needles - Syringes returned by PWIDs to the programme within the geographical intervention area during the reporting quarter.                                                                                                                                                             | Collections Register<br><br>ORW/ PE Register                                            | 80% of indicator 4.6 (Needles distributed) |  |
| 5 Structural Interventions/ Enabling Environment |                                                                                                                        |                                                                                                                                                                                                                                                                                                           |                                                                                         |                                            |  |
| 5.1                                              | Number of advocacy workshops/ meeting conducted with key stakeholders during the reporting quarter                     | Total number of advocacy workshops/ meetings conducted with key stakeholders (e.g. law enforcement agencies, religious leaders, local administration, entertainment establishments owners, etc.) to promote an enabling environment for key populations during the reporting quarter.                     | Advocacy/ Meeting Register                                                              | As per the Project Proposal                |  |
| 5.2                                              | Number of participants at the advocacy workshops/ meeting conducted with key stakeholders during the reporting quarter | Total number of participants at the advocacy workshops/ meetings conducted with key stakeholders (e.g. law enforcement agencies, religious leaders, local administration, entertainment establishments owners, etc.) to promote an enabling environment for key populations during the reporting quarter. | Advocacy/ Meeting Register                                                              | As per the Project Proposal                |  |

|                                      |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                          |  |
|--------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------|--|
| 5.3                                  | Number of incidents of violence reported against the key populations during the quarter | Violence includes any incident faced by the key populations like extortion, abuse, arrest / detention by police, beating by gangs/goons, rapes, beating by clients and partners targeted at key populations. Report all cases for the reporting quarter.                                                                                                                              | Crisis Reporting Format | None                                     |  |
| 5.4                                  | Number of incidents of violence addressed during the quarter                            | Addressing of cases means that peers and/ or project staff met with affected community members within 24 hours to register a complaint with the police or other legal / mutually agreeable channel against perpetrators of violence and arranged for appropriate help. The case does not have to be necessarily resolved to be counted in this indicator as a solution may take time. | Crisis Reporting Format | 100 % of indicator 5.3                   |  |
| 6 Infrastructure and human resources |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                          |  |
| 6.1                                  | Number of Project supported health facility                                             | Total number of service delivery points or health facilities (GOK, Private, NGO, or FBO) supported by the project/ or linked with the project as a referral centre to offer services for key populations within a defined geographical region.                                                                                                                                        | Project Proposal        | As per the Project Proposal              |  |
| 6.2                                  | Number of Project owned Drop In Centres                                                 | Total number active Drop In Service Centres (Safe spaces for key populations) established / owned by the project to offer services to key populations.                                                                                                                                                                                                                                | Project Proposal        | As per the Project Proposal              |  |
| 6.3                                  | Number of active Outreach Workers                                                       | Total number of outreach workers hired and engaged by the project for the purposes of conducting outreaches for key populations in a designated project area during the reporting period.                                                                                                                                                                                             | Attendance Register     | 100 % of agreed upon figures in proposal |  |

|     |                                 |                                                                                                                                                                                                                                                             |                     |                                          |  |
|-----|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------|--|
| 6.4 | Number of Active Peer Educators | Individuals from key populations' community that have been hired to provide outreach services in the reporting period. These individuals work with the project on a regular basis, collect data related to their activities, and may be paid an honorarium. | Attendance Register | 100 % of agreed upon figures in proposal |  |
|-----|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------|--|





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