

Key population trusted access platforms

Considerations in planning and budgeting for a key population platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers

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Abbreviations

Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
MSMIT	Men Who Have Sex with Men Implementation Tool
OST	opioid substitution therapy
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PPI	priority programme indicators
PPM	participatory programme mapping
PrEP	pre-exposure prophylaxis
PSE	population size estimate
STI	sexually transmitted infection
SWIT	Sex Worker Implementation Tool
TRANSIT	Transgender Implementation Tool
U = U	undetectable = untransmittable
UIC	unique identifier code
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Introduction: building a trusted access platform for a scaled and effective HIV response with key populations

A trusted access platform is the foundation on which effective key population programmes are built and a range of community- and clinic-based interventions and services are provided. A trusted access platform supports all key populations, both as individual members and communities, addressing common needs regardless of HIV status or other specific health-care requirements. It is also a way of working with key populations communities to establish trust and improve access to services, involving close collaboration on programme design, implementation and monitoring, and on addressing critical enablers.

Trusted access platforms may be implemented by community-based or nongovernmental organizations with support from government and donors, but they derive their effectiveness from the engagement and participation of active key populations. Access platforms may be physical, virtual or a combination of the two, but they will eventually entail contact between programme recipients and community-based and nongovernmental organizations and/or clinical services.

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



As a platform, coordinated community- and clinic-based efforts combine to build trust, reach key populations in high numbers, and encourage their uptake, retention and active participation in programmes. This operational guidance does not go into detail about specific services (which are covered elsewhere and referenced here). Similarly, it does not provide a detailed structure and staffing of virtual outreach and service provision and referral since they vary widely. Rather, the focus of this document is on the principles of building a solid foundation for key population service provision, one that enjoys high levels of trust and participation with and by key populations in community and clinic settings using traditional models, and that recognizes that these can be adapted or modified with virtual outreach for some subpopulations among the key population beneficiaries.

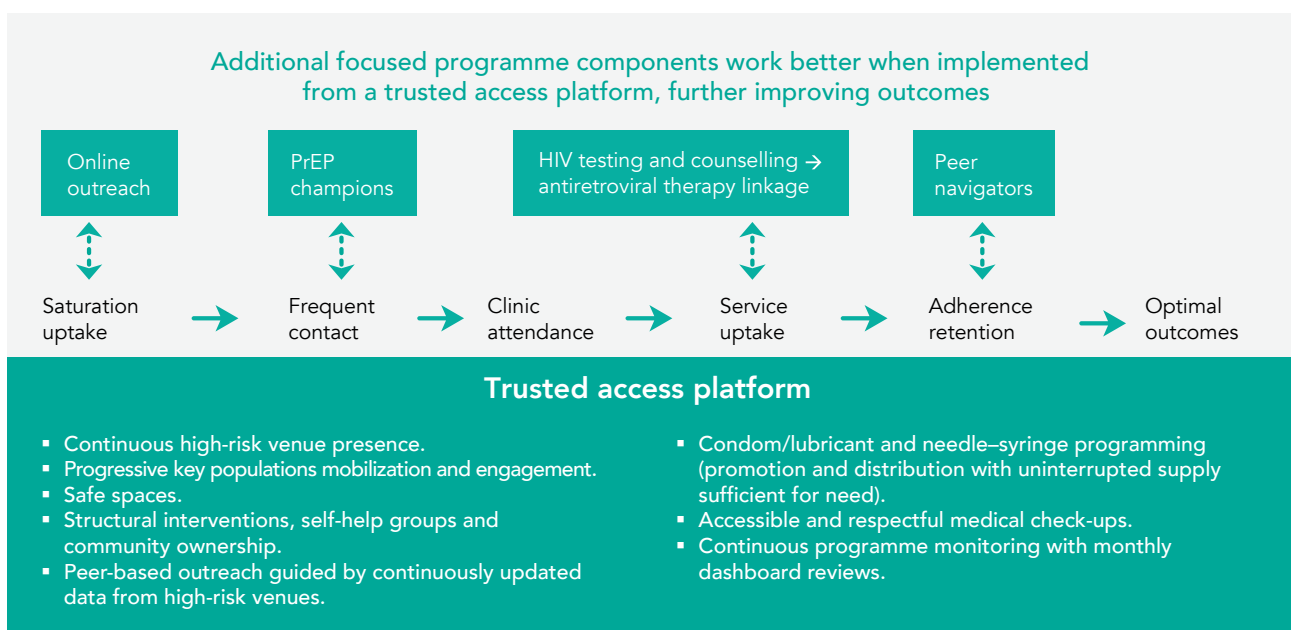
The community access platform described here is intended for communities that have been involved in traditional physical outreach, including subgroups that can now be reached online. Indeed, there are distinct subgroups of key populations who can only be engaged online, such as key population members who may not associate closely with community organizations for fear of disclosure, those

who have internalized stigma or those with a preference for alternate health service options. As such, there is no single model that works in every setting for every key population: programmes need to adapt to evolving contexts and key population needs.

A trusted access platform has several advantages over narrowly designed programmes. Experience has shown that single-focus (vertical) services—whether for condoms, HIV testing, pre-exposure prophylaxis (PrEP) or other services—often struggle to reach many key populations or those at highest risk, resulting in low service uptake, use, retention and impact. Additionally, if these vertical services are able to reach individuals, there is a missed opportunity for a more comprehensive encounter. Compounding the problem, struggling programmes often resort to narrowly focused intervention “fixes” in order to attract key populations or link them to specific services, and to boost flagging adherence and retention over time. Such partial responses are expensive and may breach confidentiality.

When those same services, however, are offered on top of a trusted access platform that maintains a continuous presence in communities, responds quickly to community concerns and

Figure 1. Trusted access platform as foundation for multiple interventions and services



When services, are offered on top of a trusted access platform that maintains a continuous presence in communities, higher levels of uptake and retention are feasible.

promotes regular medical check-ups (see Figure 1), much higher levels of uptake and retention are feasible. The increased efficiency and strengthened confidentiality that result further build community trust and participation in programmes, and foster community cohesion.

In fact, a single intervention or service is more easily and effectively introduced when it is offered and promoted from a solid and trusted access platform, as Figure 1 demonstrates. Gold-standard examples from diverse settings report near optimal outcomes for condom use, HIV testing coverage, screening for sexually transmitted infections (STIs), PrEP uptake, linkages to antiretroviral therapy and retention with minimal loss to follow-up (1–3).

Moreover, routine programme data from well-designed community-based platforms are reliable, easy to interpret, and pertinent to programming, as they come from defined locations with targets based on local population size estimates (PSE). Continuous monitoring of process and outcome data

shows progress towards targets and permits both the timely identification of problems and the implementation of solutions. As a result, many such programmes have demonstrated optimal outcomes (such as high reported condom use and antiretroviral therapy uptake and retention) as well as impact on STI and HIV trends. In addition, community-based monitoring—of service quality, stigma and discrimination, violence and more—facilitates improving services and delivery approaches for the specific needs of key populations.

What are the main elements of a trusted access platform? Figure 2 illustrates a number of features and elements of a trusted access platform that are described briefly in this document. Effective key population programmes conduct the following peer interventions with a continuous presence at high-risk venues (or virtual hotspots), including structural interventions; condom, lubricant, needle and syringe promotion and distribution based on need; and regular medical check-ups (see Figure 2). Management

Figure 2. Trusted access platform as a foundation for multiple interventions and services

Intervention design for impact

- Build trusted access platform**
 - Programme design, standards and monitoring plan for community- and clinic-based interventions.
- Engage community with continuous hotspot presence**
 - Venue-based/online peer education.
 - Safe space.
 - Structural interventions.
 - Condoms/prevention commodities.
- Promote and provide regular medical check-ups**
 - Quarterly check-ups.
 - Specific services.

Management for scale/coverage

- Plan implementation for scale and saturation coverage**
 - High-level mapping with gap analysis/planning cycle.
 - Local participatory mapping (integrated with outreach).
 - High-level support work on critical enablers.
 - Addressing safety, security and human rights.
- Manage and monitor for continuous improvement**
 - Common minimum programme.
 - Clear targets for uptake and utilization.
 - Dashboard reviews of key indicators.
- Build capacity and community ownership**
 - Capacity-building for community and staff.
 - Self-help groups.

While platform principles of trust and access are still relevant, other approaches are needed to reach key populations in prisons, closed settings or virtual networks.

support (also in Figure 2) builds on regular programme mapping and PSE in high-risk venues, continuous monitoring of programme data, regular dashboard reviews of priority programme indicators (PPI) and capacity-building for community and staff.

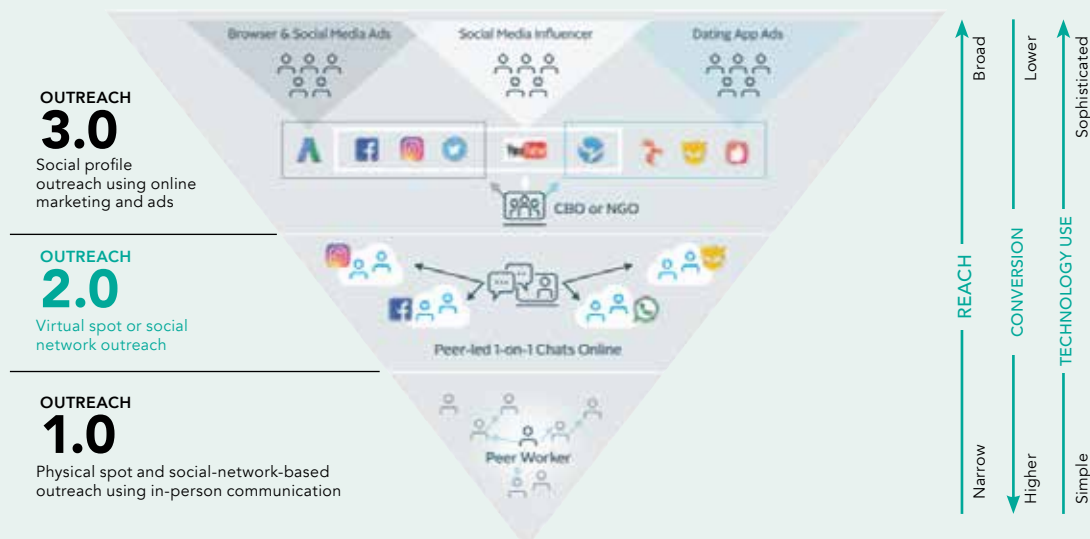
Importantly, such intervention platforms work best when there are strong community mobilization and engagement, both of which are integral to the implementation process. Experience from several communities that have successfully organized themselves to confront HIV and STIs demonstrate the feasibility of community empowerment, its importance in building trusted access platforms, and the important synergies that arise from active community participation and leadership.

Key population implementation tools (SWIT, MSMIT, TRANSIT and IDUIT) are primary references for this brief, and they can be consulted for more details on designing effective key population programmes (see key resources and example of guidances and tools, below).¹ Trusted access platforms described here apply to programmes that reach key population members—female, male and transgender sex workers; gay men and other men who have sex with men; transgender persons; and men and women who use drugs—in community settings. While platform principles of trust and access are still relevant, other approaches are needed to reach key populations in prisons, closed settings or virtual networks.

Virtual/online outreach

Globally, there are several models of combined physical and virtual platforms that have been adapted for reach and to respond to situations where physical encounters carry the risk of stigmatization, harassment or arrest (see Figure 3). Increasingly sophisticated social media platforms can bypass some of these barriers, but they also carry new and sometimes less understood privacy and security risks.

Figure 3. Generations of HIV outreach



Source: Going online to accelerate the impact of HIV programs. Washington (DC): FHI 360, LINKAGES Project; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vision-going-online.pdf>, accessed 4 May 2020).

¹Resources that are specific to virtual outreach are indicated with two asterisks: **.

- The following programme management areas (from Chapter 6 of SWIT) are expanded with an operational focus, using examples of implementation experience and recognized good practices (4):
- Establishing programme standards, data monitoring systems and an evaluation plan.
 - Setting up management structures.
 - Implementing the programme in stages.
 - Ensuring peer participation in programme design and implementation.
 - Developing staff capacity.

Key resources and examples of guidances and tools

1. Key population implementation tools:
 - i. WHO, UNFPA, UNAIDS, NSWP, The World Bank, UNDP. Implementing comprehensive HIV/STI programmes with sex workers (SWIT). Geneva: WHO; 2013 (<https://www.nswp.org/resource/sex-worker-implementation-tool-swit>, accessed 4 May 2020).
 - ii. UNFPA, The Global Forum on MSM and HIV, UNDP, UNAIDS, WHO, USAID et al. Implementing comprehensive HIV and STI programmes with men who have sex with men (MSMIT). Geneva: WHO; 2015 (<https://www.who.int/hiv/pub/toolkits/msm-implementation-tool/en/>, accessed 4 May 2020).
 - iii. UNDP, IRGT, UNFPA, UCSF, JHSPH, WHO et al. Implementing comprehensive HIV and STI programmes with transgender people (TRANSIT). New York: UNDP; 2016 (<https://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-transgender-people-practical-guidance>, accessed 4 May 2020).
 - iv. UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs (IDUIT). Vienna: UNODC; 2017 (<https://www.inpud.net/en/iduit-implementing-comprehensive-hiv-and-hcv-programmes-people-who-inject-drugs>, accessed 4 May 2020).
2. Program self-assessment tool for key populations. Geneva: Global HIV Prevention Coalition; 2020 (<https://hivpreventioncoalition.unaids.org/resource/hiv-prevention-self-assessment-tool-psat/>, accessed 4 May 2020).
3. HIV prevention, diagnosis, treatment and care for key populations: consolidated guidelines. Geneva: WHO; 2016 (<https://apps.who.int/iris/bitstream/handle/10665/258967/WHO-HIV-2017.05-eng.pdf>, accessed 4 May 2020).
4. HIV information note. September 2019. Geneva: The Global Fund; 2019 (https://www.theglobalfund.org/media/4765/core_hiv_infonote_en.pdf?u=637153280170000000, accessed 4 May 2020).

5. Technical brief on HIV and key populations. Geneva: The Global Fund; 2019 (https://www.theglobalfund.org/media/4794/core_keypopulations_technicalbrief_en.pdf?u=637153281420000000, accessed 4 May 2020).
6. National implementation guidelines for STI and HIV programming among young key populations. Nairobi: Ministry of Health (Kenya); 2018 (<https://www.iavi.org/phocadownload/userupload/National%20Implementation%20Guidelines%20for%20HIV%20and%20STI%20Programming%20among%20YKPs%202018.pdf>, accessed 4 May 2020).
7. ** Going online to accelerate the impact of HIV programs. Washington (DC): FHI 360, LINKAGES Project; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vision-going-online.pdf>, accessed 4 May 2020).
8. ** Empowering LGBTQ+ organizations in at-risk areas to protect themselves digitally. In: Safe Queers [Internet]. Safe Queers; c2020 (<https://safequeers.org/>, accessed 4 May 2020).

Part 1:

intervention design for impact

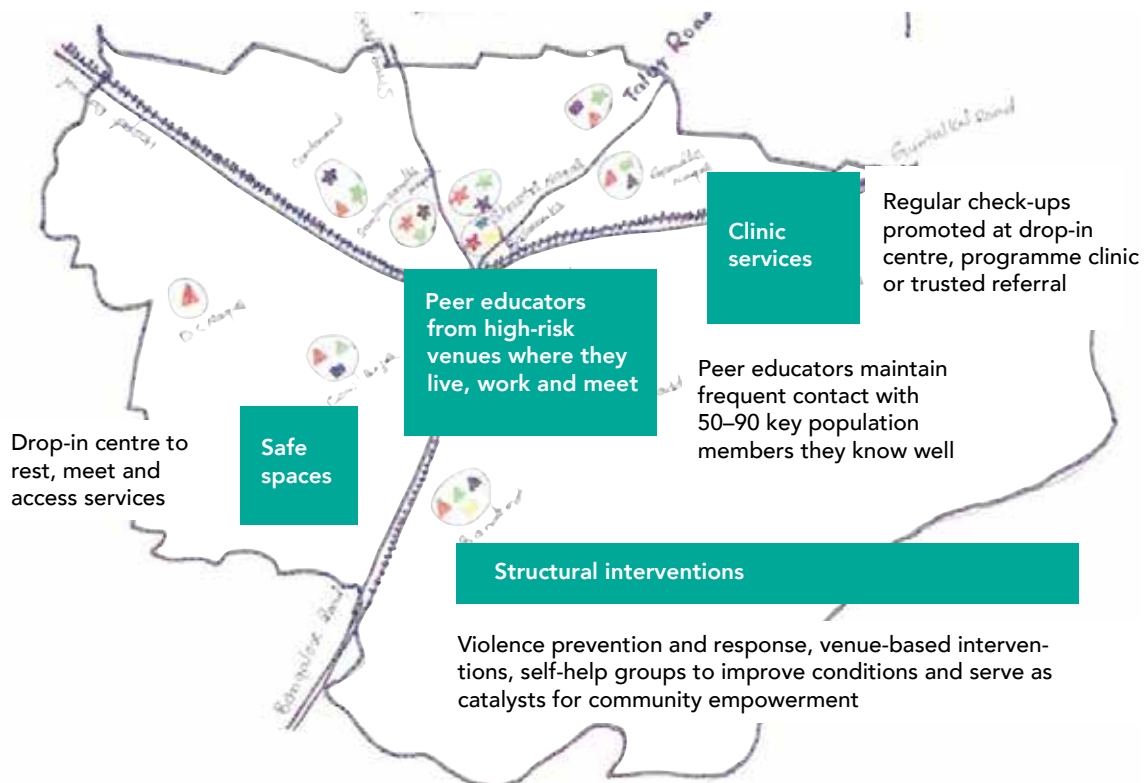
Trusted access platforms are built in close proximity to key population communities, and they maintain a continuous high-risk venue presence.

Trusted access platforms are built in close proximity to key population communities, and they maintain a continuous high-risk venue presence. This means peer educators are engaged where they meet, work or live, and they are enabled to conduct outreach based on their knowledge of high-risk venues and their rapport with peers. Safe spaces enhance outreach by providing security and building community trust, and they also provide space for counselling, meetings (and in some cases) clinical service visits. Structural interventions make the local environment safer for key populations and reduce barriers to prevention and service utilization. Regular medical check-ups, where a wide range of clinical services are offered, are promoted for all key

populations regardless of their HIV status, maintaining confidentiality and building trust. Additional programme efforts—to promote HIV testing, PrEP, antiretroviral therapy and more—work best to boost uptake, adherence and retention when implemented from trusted access platforms.

As a platform, coordinated community and clinic-based efforts combine to build trust, reach key populations in high numbers and encourage their uptake of (and retention and active participation in) programmes. The following sections describe how to ensure a continuous presence at high-risk venues while providing needed services through both community and clinic-based interventions.

Figure 4. Trusted access platform as foundation for multiple interventions and services



Section 1: engaging community with continuous high-risk venue presence

What is it?

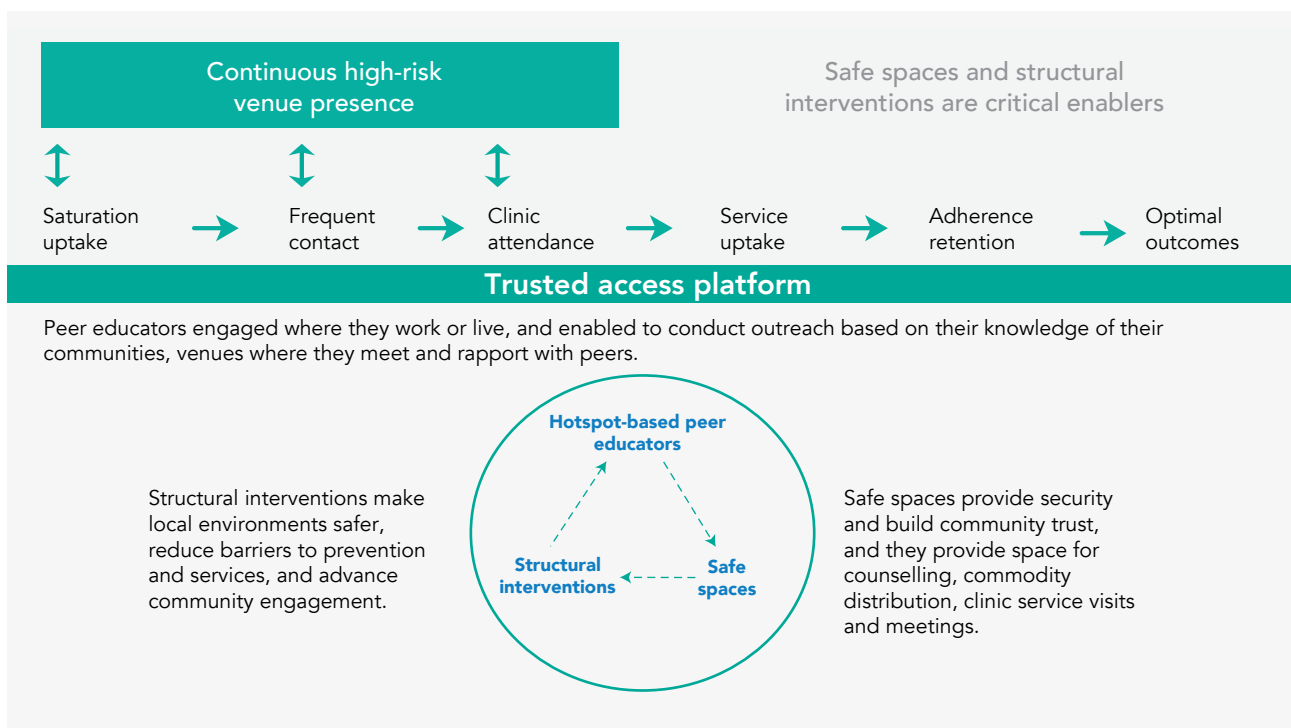
A continuous presence at high-risk venues means that peer educators are engaged where they meet, work or live, and that they are enabled to conduct outreach based on their knowledge of high-risk venues and their rapport with their peers. Safe spaces—whether physical or virtual—enhance outreach by providing security and building community trust, while also providing space for counselling, meetings, delivery of prevention commodities and (in some cases) clinical service visits. Structural interventions make the local environment safer for key populations and reduce barriers to prevention, testing, treatment and care. They also increase and sustain demand for services and increase the ability of key populations to organize and self-advocate.

Why is it worth investing in?

Engaging key population communities and building trust in the programme means investing in the key populations themselves as active programme participants. This is done through training, support, self-help groups, nurturing the formation or strengthening of networks, and similar activities. Peer educators who live, work or meet in identified high-risk venues are much better placed to perform effective outreach than peer educators who travel from outside the location with a mobile testing team. Participatory programme mapping (PPM) provides an early opportunity for engaging communities in the process and identifying existing key population leaders as potential peer educator candidates and programme advocates (see Section 9).

Engaging key population communities and building trust in the programme means investing in the key populations themselves as active programme participants.

Figure 5. Peers who live or work in identified high-risk venues are well placed to perform effective outreach



Peer education based in high-risk venues is a starting point for microplanning, which empowers key populations to lead outreach efforts.

Peer education based in high-risk venues is also a starting point for microplanning, which empowers key populations to lead outreach efforts—building on the knowledge that peer educators have of their communities—and to share their experiences with the other key populations who live, work or meet there. Methods and resources for recruiting peer educators and supporting their outreach work can be adapted to different settings.

Online/virtual presence can vary depending on the subgroups of key population members being reached. If those subgroups are similar to the members who are being reached in the physical location, then the online platform can act as a substitute or supplement for

in-person contact. It could, for example, be used to advertise existing services that are on offer. If the programme is trying to reach a much larger key population community that is not interested in the physical services offered—such as people who do not disclose their status or those who want quick, anonymous access to HIV services because they fear disclosure among their community or because of community differences—a different set of approaches to engage the community and build trust will be needed. These new approaches might include new ways to reach them (such as influencers) and link them to HIV services (online booking, for instance, or more diverse service options like private or home-based services).



What is needed?

- Outreach designed to ensure a continuous high-risk venue presence (or online presence).
- PPM to identify local venues and engage key population communities. This should occur at programme start-up and be updated periodically.
- Safe spaces.
- Peer educators selected from high-risk venues where they work and are trained (venue-based peer education).
- If plans are to create virtual/online outreach, then equipment, subscriptions to virtual/online outreach, and staff who are skilled in social media and data are needed.



Is it in the budget?

- Outreach designed for a continuous high-risk venue presence: a sufficient number of peer educators based on the population, remuneration, travel/phone reimbursements, initial training, refresher training and microplanning materials (e.g., forms, pens/pencils, tablets with associated software development/adaptation, and connectivity costs) (see Section 4).
- Safe spaces: rent, refurbishment, furnishings and recurrent costs (see Section 2).
- Structural interventions/self-help groups: legal literacy training, paralegal training, regular meetings with travel support and seed funding for interventions. May also include: child protection cadres among peers, linkage to educational assistance/second chance education, peer gender-based violence support cadres, lay mental health support and more (see Section 3).
- PPM and site validation activities: forms, data analysis, and remuneration and travel support (see Section 9).
- Social media mapping, social network outreach and social influencer outreach (see Section 4).

Key resources and examples of guidances and tools

1. Avahan, Bill & Melinda Gates Foundation. Micro-planning in peer led outreach programs—a handbook. New Delhi: Bill & Melinda Gates Foundation; 2013 ([http://docs.gatesfoundation.org/no-search/Documents/Microplanning%20Handbook%20\(Web\).pdf](http://docs.gatesfoundation.org/no-search/Documents/Microplanning%20Handbook%20(Web).pdf), accessed 4 May 2020).
2. Thompson LH, Bhattacharjee P, Anthony J, Shetye M, Moses S, Blanchard J. A systematic approach to the design and scale-up of targeted interventions for HIV prevention among urban female sex workers. Rajajinagar (India): Karnataka Health Promotion Trust; 2012 (<http://documents.worldbank.org/curated/en/336971468151769158/pdf/NonAsciiFileName0.pdf>, accessed 4 May 2020).
3. The Global Fund, WHO, UNDP, PEPFAR, University of Manitoba, UNAIDS et al. Using programmatic mapping to improve program access and coverage for key populations: guidelines for countries. 2016 (<https://hivpreventioncoalition.unaids.org/resource/using-programmatic-mapping-to-improve-program-access-and-coverage-for-key-populations-guidelines-for-countries/>, accessed 6 August 2020).
4. Monitoring guide and toolkit for key population HIV prevention, care and treatment programs. Durham (NC): FHI 360/LINKAGES Project; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-monitoring-tools.pdf>, accessed 4 May 2020).
5. Emmanuel F, Persaud N, Weir SS, Bhattacharjee P, Isac S. Programmatic mapping: providing evidence for high impact HIV prevention programs for female sex workers. *JMIR Public Health Surveill.* 2019;5(2):e12636 (<https://publichealth.jmir.org/2019/2/e12636/pdf>, accessed 4 May 2020).
6. ****** Going online to accelerate the impact of HIV programs. Washington (DC): FHI 360/LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vision-going-online.pdf>, accessed 4 May 2020).

Section 2: safe spaces

What is it?

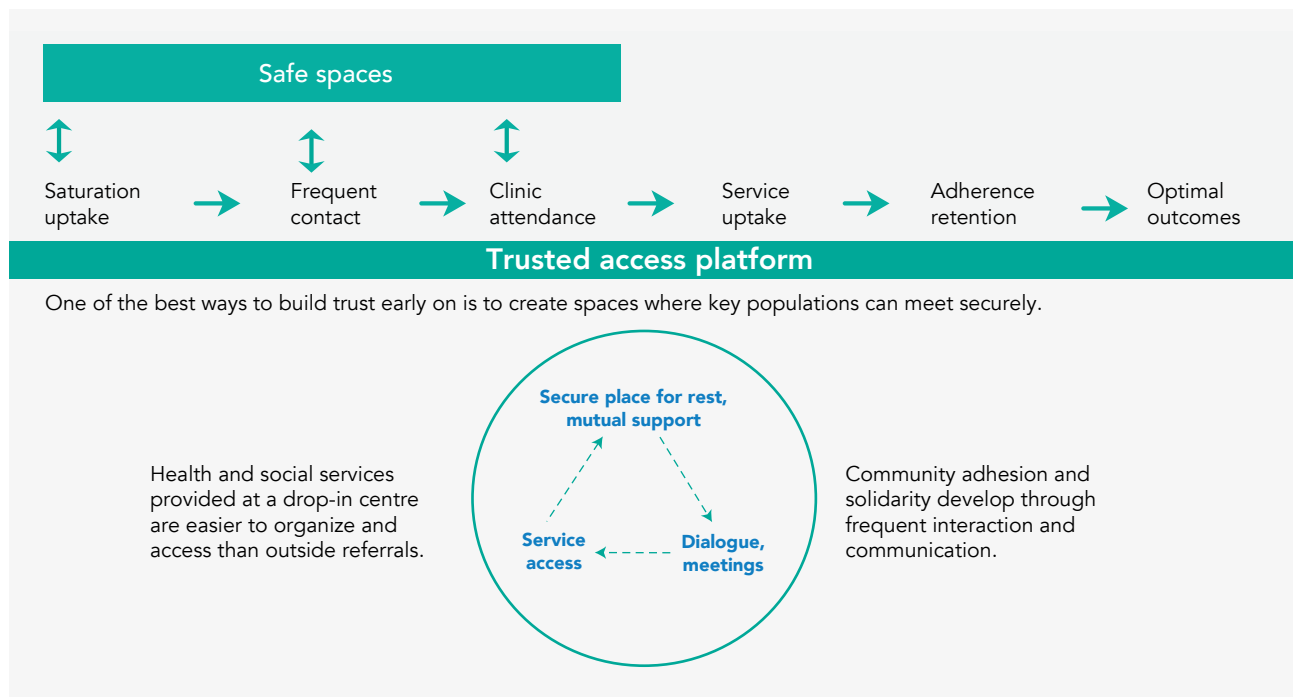
One of the most effective things that can be done early when starting a key populations programme is to establish safe spaces like drop-in centres. Such places should be welcoming and secure, and they should provide opportunities for rest and meetings, services and networking. In some cases, some of the offered services may be online.

Safe spaces like drop-in centres provide simple amenities that attract key populations and facilitate community cohesion and networking.

Why is it worth investing in?

Safe spaces provide simple amenities—such as shelter, washroom facilities and a place to rest with peers—that attract key populations and facilitate community cohesion and networking. They can also progressively be improved to meet community needs, such as by housing part-time or full-time counselling and clinical services (as illustrated in Section 6). They also can help organize community dialogue, and they can solicit input from service recipients among key populations on the quality and accessibility of services provided at the community level, and on project clinical and referral medical services.

Figure 6. Safe spaces are welcoming and secure, and they provide opportunities for rest, networking, meetings and services





What is needed?

- A safe space that is convenient to the population served and chosen with input from the community.
- A staffing plan.
- Plans for activities, meetings and services to be offered.
- A security plan.



Is it in the budget?

- Safe spaces, such as drop-in-centres for high-risk venues: rent, refurbishment (including storage space for community members) and furnishings. These are usually cost-effective when located in settings with a large number of key population members (to be set by the programme, but often at least several hundred people). Virtually organized sites in homes have minimal or no cost.
- Running costs: utilities, staffing (ideally from the community, with peer educators taking turns staffing the drop-in centre, for which they are remunerated) and security.
- Provision of prevention commodities (e.g., condoms, lubricants, needles and syringes).
- An activity budget for outreach, structural interventions and so on (see Sections 3 and 4).
- If counselling and clinical services are offered at the drop-in centre:
 - Supplies (if not available from government services).
 - Equipment.
 - Renovations for visual and auditory privacy.
- Security cameras to monitor incidents of violence occurring inside and around the drop-in centres.

Key resources and examples of guidances and tools

1. Safety and security toolkit: strengthening the implementation of HIV programs for and with key populations. Durham (NC): FHI 360; 2018 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-safety-security-toolkit.pdf>, accessed 4 May 2020).

Section 3: structural interventions

A range of structural conditions, including violence, venues, and other vulnerabilities, have been effectively addressed by key population communities with programme support.

What is it?

Critical enablers for working effectively with key populations include:

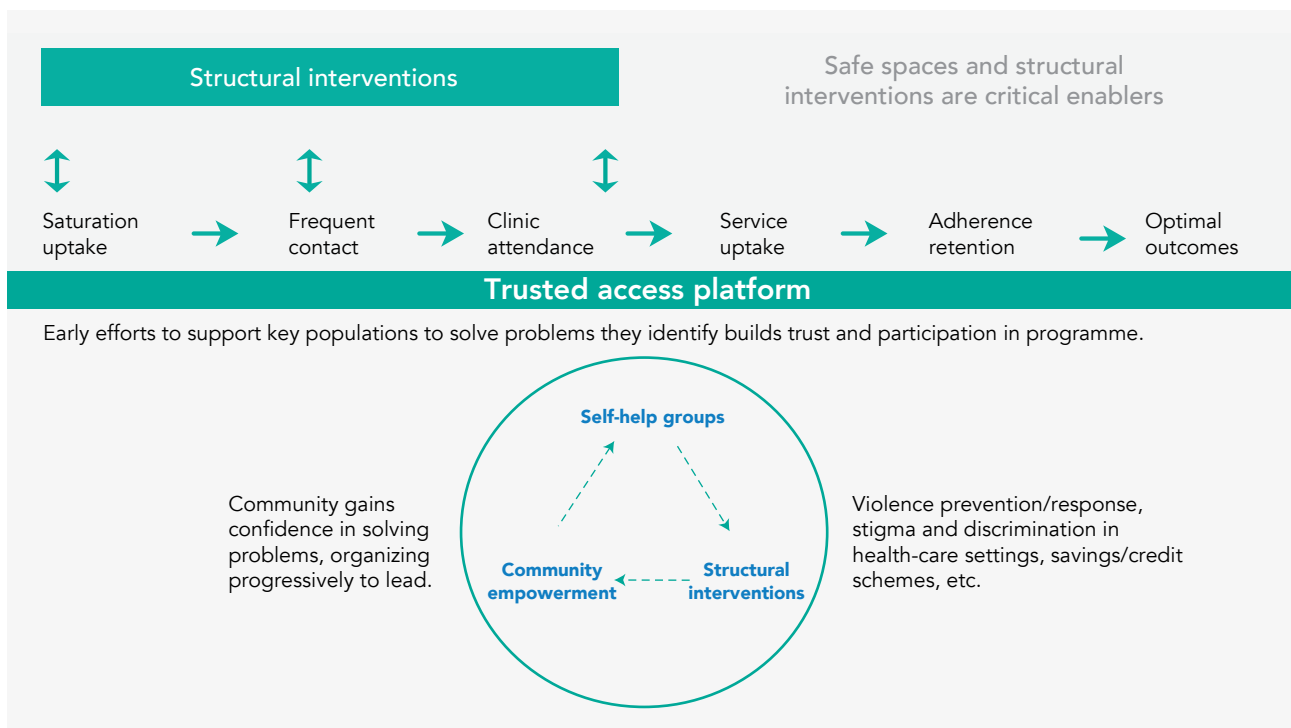
- Supportive legislation and policy.
- Assessing and addressing stigma and discrimination.
- Community empowerment.
- Addressing violence and rights violations.
- Ensuring access to health services.
- Ensuring the safety and security of implementers, particularly peer educators.

A trusted access platform provides opportunities for advancing most of these enablers through structural interventions at the local level with the community.

Key population programmes should work to improve conditions in high-risk venues. A range of structural conditions—including violence (prevention and response), venues (security, support for condom use, and needle–syringe programmes), and other vulnerabilities (financial, child welfare, housing, and access to government entitlements and education for children)—have been effectively addressed by key population communities with programme support.

Self-help groups are effective ways to address structural conditions while

Figure 7. Addressing structural issues builds trust, removes or mitigates barriers to prevention and service access, and improves conditions



promoting community empowerment. With the support of the programme, groups of 10 to 15 key population members can form a self-help group to address specific structural conditions that they identify and prioritize. The confidence and cohesion built into the process facilitates community organization and empowerment, all while building trust, participation and ownership of the programme. Empowered groups also contribute to regional and national policy efforts.

Why is it worth investing in?

Addressing at least some of the structural issues affecting key populations builds trust in the programme, removes or mitigates barriers to prevention, service access and adherence, and improves conditions (all of which are critical enablers).



What is needed?

- Self-help groups or similar community processes to identify and solve/ameliorate key structural problems.
- Addressing violence through a rapid response mechanism and related clinical services, advocacy with local police, paralegal training, legal literacy and rights (Know Your Rights) training and so on.
- Addressing venues and undertaking advocacy with owner/managers.
- Addressing health-care provider stigma, conducting advocacy with providers and supplying training.
- Addressing other vulnerabilities through saving/credit plans, child care and homelessness programmes, and more.
- Linkage with national key population networks for advocacy.



Is it in the budget?

- Activities to assess, prioritize and address structural issues, such as violence prevention/response, safety and security, and advocacy with local gatekeepers, decision-makers and police.
 - Start-up costs of a violence response plan: training, making connections with police, lawyers and health facilities, form printing, travel support.
 - Legal literacy, rights training (Know Your Rights) and para-legal training: understanding local laws through collaboration with the legal community and developing appropriate training materials for key population members and police.
 - Advocacy with religious, traditional and community leaders, and with venue owners.
 - Child protection/welfare, access to educational assistance for both young and older key populations, access to housing, access to government entitlements, savings/credit plans, child care, and other structural interventions to address priorities identified by the community or self-help groups.
 - Health-care provider training for respectful service and responses to violence, with community input into trainings.
 - Addressing stigma and discrimination.
 - Transport support for regular meetings with police, health-care providers, relevant government officials and others.
- Budget for self-help group start-up and regular meetings: venue identification (if not at a drop-in-centre), stationery, refreshments and seed funding.

Key resources and examples of guidances and tools

1. Avahan, Bill & Melinda Gates Foundation. Community led crisis response systems. New Delhi: Bill & Melinda Gates Foundation; 2013 ([http://docs.gatesfoundation.org/no-search/Documents/Community%20Led%20Crisis%20Response%20\(Web\).pdf](http://docs.gatesfoundation.org/no-search/Documents/Community%20Led%20Crisis%20Response%20(Web).pdf), accessed 4 May 2020).
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 - i. Dayton R, Morales GJ, Dixon KS. A guide to comprehensive violence prevention and response in key population programs. Durham (NC): FHI 360; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vpr-guide.pdf>, accessed 4 May 2020).
 - ii. Dayton R. Law enforcement training: preventing and responding to violence against key populations to increase access to justice and strengthen the HIV response. Durham (NC): FHI 360; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-le-training-manual.pdf>, accessed 4 May 2020).
 - iii. Dayton R, Morales GJ, Dixon KS. Health care worker training: preventing and responding to violence against key populations. Durham (NC): FHI 360; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-hcw-training-manual.pdf>, accessed 4 May 2020).
4. Fast-Track and human rights: advancing human rights in efforts to accelerate the response to HIV. Geneva: UNAIDS; 2017 (https://www.unaids.org/sites/default/files/media_asset/JC2895_Fast-Track%20and%20human%20rights_Print.pdf, accessed 4 May 2020).
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Section 4: strengthening outreach (including microplanning)

Strong, venue-based outreach engages communities and builds trust and participation in programmes.

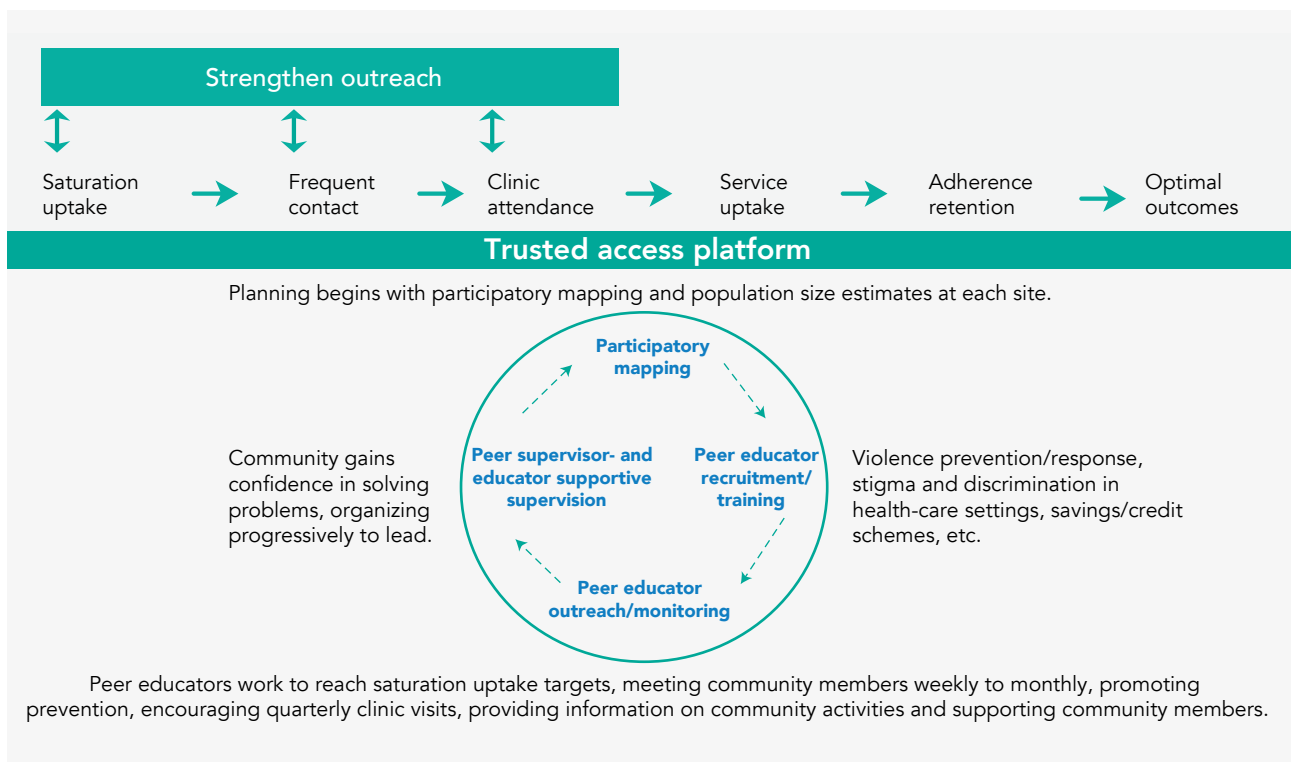
What is it?

Key population programmes should maintain a continuous presence at high-risk venues by engaging, training and supporting peer educators who are based at high-risk venues to conduct outreach and peer interventions in their communities. Microplanning is one systematic approach to strengthening community outreach: it builds on the intimate knowledge of high-risk venues possessed by peer educators in order to maintain a continuous high-risk venue presence, support prevention and promote clinic attendance. Frequent supportive supervision of peer educators by peer supervisors includes monitoring progress towards targets and planning upcoming work.

Why is it worth investing in?

Strong venue-based outreach engages communities and builds trust and participation in programmes. Microplanning empowers key population communities to lead their programmes by shifting the focus of programme monitoring and decision-making to the local level. Peer supervisors provide supervision and ongoing motivation and training, supporting local problem-solving and consolidating outreach data if they are in paper-based formats.

Figure 8. Key population programmes engage, train and support venue-based key populations to conduct outreach and peer interventions in their communities





What is needed?

- PSE and community mapping: planning and budgeting for outreach with a continuous high-risk venue presence begins with the PSE for each local site (town, district or urban area). A virtual hotspot mapping provides entry points for online outreach to communities at higher risk.
- Peer educators: a ratio of approximately 50 key population members to one peer educator is a rough guide, although it can be adjusted based on the size and location of high-risk venues. For instance, large, high-risk venues may require several peer educators, while several smaller venues may form a cluster covered by one peer educator. Ratios of up to 90:1 have worked in some settings where key population communities are more cohesive and easier to reach. Frequent informal contact with key populations is the norm for peer educators who stay at high-risk venues, allowing them to build trust. With frequent contact, venue-based peer educators also can find convenient times for weekly or monthly risk reduction/discussion sessions, information sharing and support.
- Peer supervisors: peer supervisors closely support six to 10 peer educators. The role of the peer supervisor—a programme outreach worker who may be an experienced peer educator promoted to full-time staff—is to meet frequently with each peer educator to review and plan work (see Annex D).
- Microplanning: in microplanning, peer supervisors have weekly one-on-one meetings with each peer educator to review the previous one or two weeks of work (collecting forms or entering data for monitoring). They also plan the next week's work, prioritizing key populations members to be contacted based on their risk level or if they are due for a clinic visit. These weekly visits motivate peer educators while focusing outreach efforts and ensuring timely data for monitoring progress towards targets. As part of the monitoring system, peer supervisors may consolidate the paper-based forms of peer educators for key indicators to be discussed locally and reported upward.



Is it in the budget?

- Sufficient number of peer educators for the intended key population (approximately 1:50).
- Sufficient number of peer supervisors to support peer educators (1:6 to 1:10).
- Support for peer educators with remuneration, training, travel, phone/data support and necessary equipment.
- Support for peer supervisors with salary, travel, phone and data support and necessary equipment.
- Support for frequent, regular peer educator–peer supervisor meetings (weekly one-on-one meetings to review individual performance and undertake planning).
- Periodic risk assessment (using a simple tool, updated quarterly) helps peer educators prioritize higher-risk clients for more frequent outreach contacts. It also can be used to estimate need for prevention commodities (See Section 5).
- Monthly meetings between peer educators and peer supervisors to review key indicators.
- Participatory programme mapping and site validation activities (see Section 9).
- Social media mapping for virtual/online outreach.

Key resources and examples of guidances and tools

1. Avahan, Bill & Melinda Gates Foundation. Micro-planning in peer led outreach programs—a handbook. New Delhi: Bill & Melinda Gates Foundation; 2013 ([http://docs.gatesfoundation.org/no-search/Documents/Microplanning%20Handbook%20\(Web\).pdf](http://docs.gatesfoundation.org/no-search/Documents/Microplanning%20Handbook%20(Web).pdf), accessed 4 May 2020).
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6. My life, my power: a training curriculum for peer educators on HIV prevention and risk reduction among MSM in Kenya. Nairobi: Kenyan Ministry of Health and Sanitation (Kenya); 2013 (https://publications.jsi.com/JSIInternet/Inc/Common/download_pub.cfm?id=14409&lid=3, accessed 4 May 2020).
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8. ****** Social media mapping – for planning online HIV outreach and service delivery. LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-media-mapping.pdf>, accessed 4 May 2020).
9. ****** Social influencer outreach – for HIV programs reaching at-risk populations online. LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-influencer-outreach.pdf>, accessed 4 May 2020).
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11. ****** Quick online surveys – for planning online HIV outreach and service delivery. LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-surveys-planning-online-outreach.pdf>, accessed 4 May 2020).

Section 5: prevention basics (condom/lubricant and needle–syringe programming)

Together with education on prevention and treatment, condom/lubricant and needle–syringe promotion and distribution are main components of community outreach.

What is it?

Effective condom/lubricant and needle–syringe programming for key populations requires integration and coordination between outreach and clinical services, supported by regular planning and programmatic monitoring against targets. Together with education on prevention and treatment, condom/lubricant and needle–syringe promotion and distribution are main components of community outreach. HIV self-testing kits also may be included in outreach.

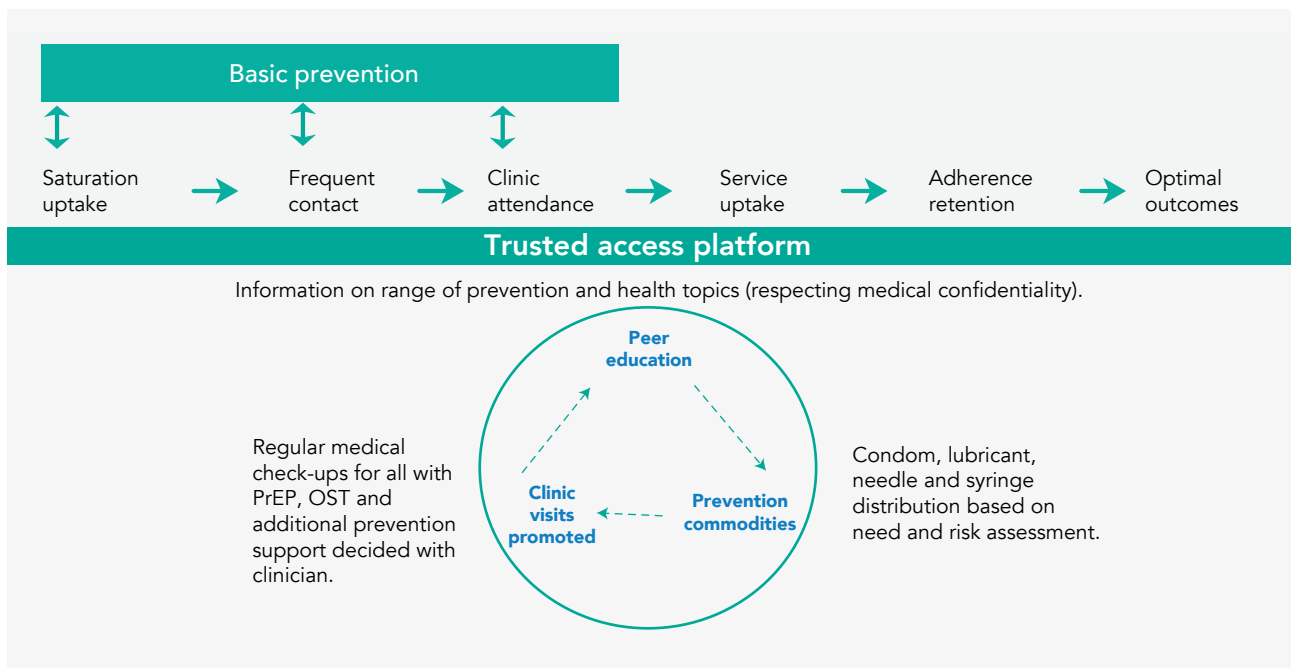
Promotion messages are reinforced at clinic visits where STI and HIV screening and treatment, PrEP, opioid substitution therapy (OST), medication-assisted

treatment, antiretroviral therapy and complementary services are offered. Promotion and distribution should be based on estimated need—in relation to the number of reported clients, partners and injections—assessed through regular needs assessment.

Why is it worth investing in?

Platform-based promotion and distribution of essential prevention commodities (condoms, lubricant, needle, syringes and sometimes HIV self-test kits) has a number of advantages over other distribution methods. These include continuous access at high-risk venues, frequent promotion through trusted peers,

Figure 9. Prevention basics (condom/lubricant and needle–syringe programming)



and reliable monitoring of distribution against estimated need. When such programmes include data collection methods, polling booth surveys or similar methods, more reliable data on the use of

condoms, lubricants and sterile injecting equipment—as well as information on access to and use of HIV prevention, testing and treatment services—can be obtained.



What is needed?

- For sexual transmission risk, condom and lubricant promotion and distribution should be prioritized and based on need. Similarly, for injection-related risk, needle–syringe promotion and distribution should be prioritized. These activities assume trained peer outreach teams working in their communities (see Section 4). Feedback from communities and information on condom and needle–syringe preferences can be provided to larger procurement systems.
- Simple tools can be adapted for periodic risk assessment (every three to six months) in order to estimate each key population’s need for prevention commodities based on sexual activity or injecting drug use.
- Polling booth surveys or similar methods permit the programme to estimate actual behaviour related to the use of condoms, lubricants and injecting equipment once or twice per year.



Is it in the budget?

- Supplies (quantities of condoms, lubricants, needle, syringes and HIV self-test kits) determined by estimating need (based on frequency of sex or injecting drug use), if not supplied by the government.
- Logistics management (mechanisms of getting supplies from central or regional warehouses to local storage, clinical settings and outreach teams). Possible budget items include:
 - Personnel at community-based or nongovernmental organizations charged with quantifying, ordering and monitoring deliveries and stocks, and with coordinating with government authorities and outreach teams.
 - Vehicles/fuel to support logistics.
- Methods for estimating need or demand for prevention commodities (commonly part of periodic risk assessments) (see Section 4).
- Polling booth surveys or similar mini-surveys to assess use: developing survey methodology and tools, training, analysis and dissemination of findings. **[Note:** these are not the larger, more rigorous integrated biological and behavioural surveillance surveys that are performed every few years. Rather, they are smaller, programmatic “dipstick” surveys that enable managers to understand if the program is moving in the right direction.]

Key resources and examples of guidances and tools

1. Third national behavioural assessment of key populations in Kenya: polling booth survey report. Nairobi: National AIDS & STI Control Programme (Kenya); 2018 (<http://www.childrenandaids.org/sites/default/files/2018-11/Polling%20booth%20survey%20report.pdf>, accessed 4 May 2020).
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Section 6: optimizing clinical services (regular medical check-ups)

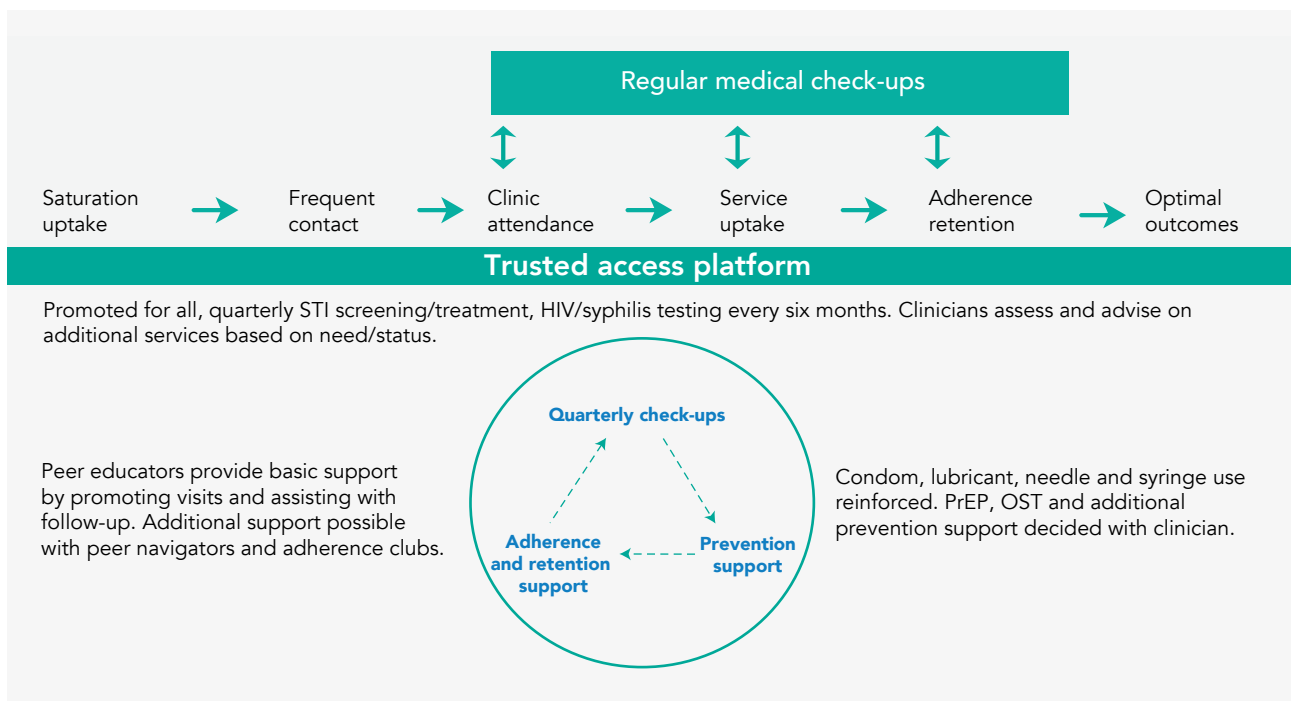
Strong venue-based outreach engages communities and builds trust and participation in programmes.

What is it?

During outreach contacts, peer educators provide information, increase prevention and treatment literacy, build trust in the programme, and supply condoms and lubricants (and needle and syringes) according to need. Peer educators also promote preventive and curative services and mobilize key populations to visit the programme clinic on a quarterly basis for routine check-ups, which include risk reduction counselling, STI screening and treatment, HIV testing and other services (as needed).

Peer educators promote regular medical check-ups without needing to know confidential health details such as HIV status. This approach of promoting check-ups rather than specific services safeguards medical confidentiality, builds community trust and simplifies peer educator training. The specific medical services that are needed are confidentially determined with a trained medical provider, not assessed or promoted by peers in busy, high-risk venue environments.

Figure 10. Regular medical check-ups are promoted by peer educators who don't need to know HIV status or confidential health details to encourage clinic visits

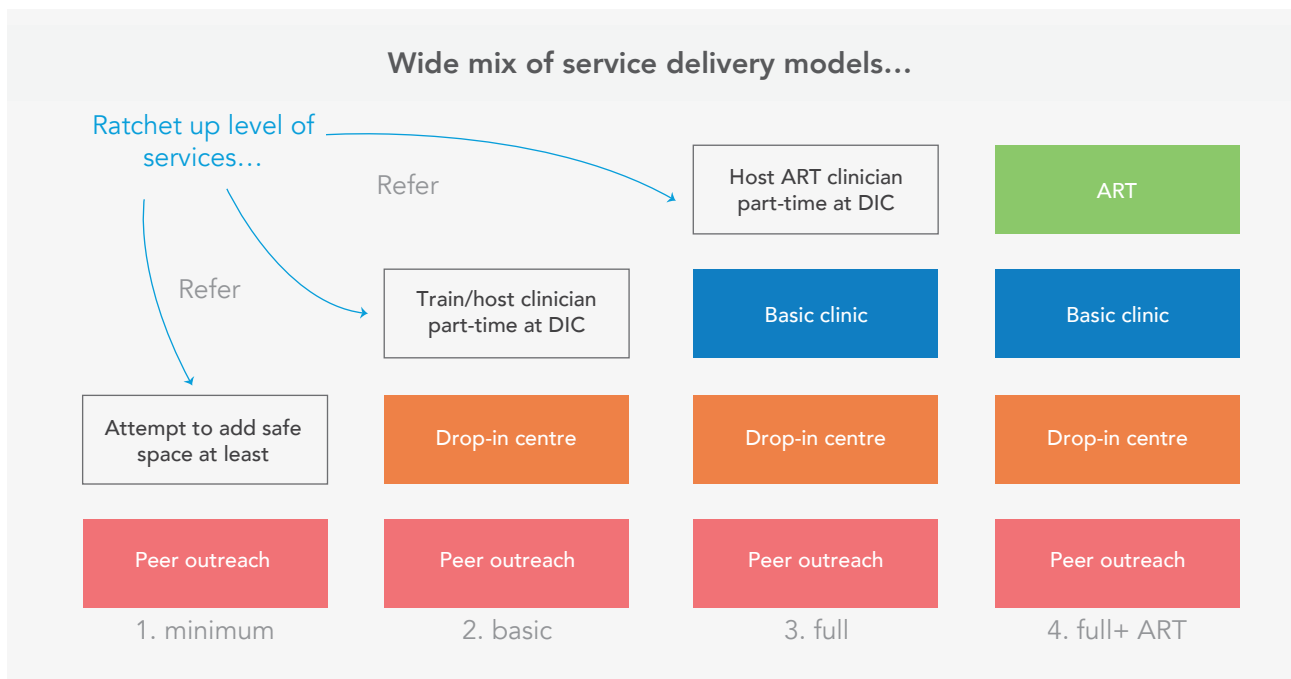


Why is it worth investing in?

Quarterly medical check-ups provide clinicians with ample opportunity to screen, treat and follow up common health conditions. For key populations on PrEP, for example, quarterly visits permit HIV testing, counselling and refills. STI screening and/or presumptive treatment for asymptomatic infections (where

indicated) also work well with quarterly visits. Where needed, clinicians can recommend more frequent follow-up for specific patients. When everyone in a key population community are encouraged to visit the clinic every three months to stay healthy, there also is less stigma for those who need to attend the clinic for specific reasons.

Figure 11. Organizing service delivery



Source: Monitoring guide and toolkit for key population HIV prevention, care, and treatment programs. Durham (NC): FHI 360/LINKAGES Project; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-monitoring-tools.pdf>, accessed 4 May 2020).



What is needed?

- Ideally, programme-run clinical services are provided close to high-risk venues. Alternatively, a range of options is needed, from hosting a government or private clinician part-time at a drop-in centre to referrals to trusted providers. As illustrated in Figure 10, the closer that services are provided to key populations, the less need there is for referral, and the higher uptake of those services and retention on them.
- Depending on the services delivery option: clinician salaries or honoraria, clinic space (can be part of safe space), basic diagnostic equipment, and reagents, medicines and supplies. Programmes relying solely on trusted referrals will likely have lower infrastructure/supply costs, but they will need to invest more in mechanisms to ensure that referrals take place and are of good quality.
- For virtual engagement: online systems to link community members to HIV services (e.g., online booking or more diverse service options, like private or home-based services).



Is it in the budget?

- Space for providing clinical services (stand-alone clinic or shared with safe space/drop-in centre) if service referral is not utilized.
- Equipment (e.g., examination table, light, diagnostic equipment and reagents, specula or anoscope).
- Medicines (for STIs and HIV; preferably also for family planning and common general ailments).
- Condoms, lubricant, needles and syringes for both outreach and clinic-based distribution (see Section 5).
- For trusted referrals: training of health-care providers, monitoring quality and acceptability of service provision, and monitoring and supporting linkage to trusted providers and retention in care (see Section 7).
- Establishment of electronic booking system and creation of referral networks for virtual/online engagement.

Key resources and examples of guidances and tools

1. STI clinic supervisory handbook. Comprehensive STI services for sex workers in Avahan-supported clinics in India. New Delhi: FHI (India Country Office) (https://www.aidsdatahub.org/sites/default/files/documents/STI_Clinic_Supervisory_Handbook.pdf, accessed 4 May 2020).
2. HIV prevention, diagnosis, treatment and care for key populations: consolidated guidelines. Geneva: WHO; 2016 (<https://apps.who.int/iris/bitstream/handle/10665/258967/WHO-HIV-2017.05-eng.pdf>, accessed 4 May 2020).

Section 7: boosting prevention and treatment cascades

A solid foundation of outreach with a continuous presence in high-risk venues permits the rapid introduction and high uptake of specific services.

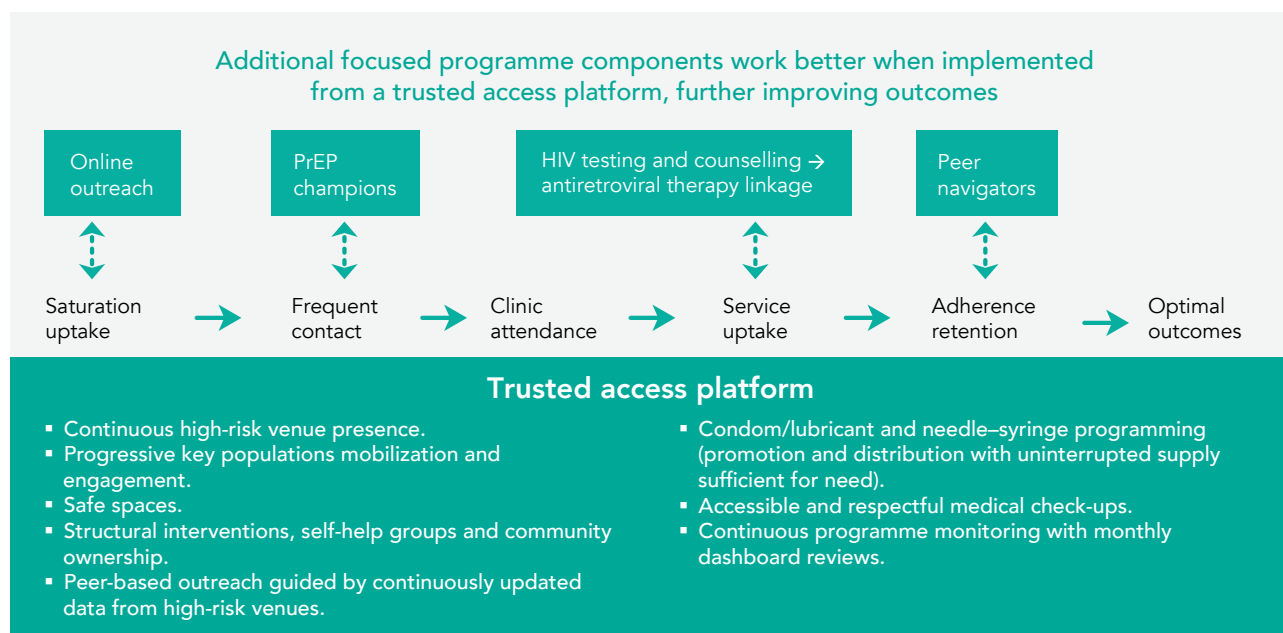
What is it?

Trusted access platforms have several inherent advantages for achieving optimal cascade outcomes, among them high levels of community trust and participation. A solid foundation of outreach with a continuous presence in high-risk venues permits the rapid introduction and high uptake of specific services. Regular medical check-ups provide frequent opportunities for clinicians to offer and provide a range of services without stigma, to encourage adherence and to maintain close follow-up. Additional programme activities with specific focus—such as online outreach, PrEP champions and antiretroviral therapy adherence clubs—generally work better

when implemented from a trusted access platform.

In addition, solid platforms provide an environment that is conducive to interventions with specific purposes, such as peer navigators or antiretroviral therapy adherence clubs. To work well and maintain confidentiality, the different types of peer workers must maintain clear and separate scopes of work (see Table 1). Peer educators work with key populations of any HIV status, supporting prevention and promoting clinic visits; peer navigators work closely with key population members living with HIV to link them to antiretroviral therapy services, and to support adherence and retention.

Figure 12. Focused activities work best when implemented from a solid platform



Why is it worth investing in?

Trusted access platforms have demonstrated optimal outcomes across both HIV prevention and treatment cascades. The main reasons for this can be attributed to the platform aspects themselves: high levels of community trust and participation, with services provided close to where key populations meet and work.

It also is often easier and more effective to add programme components with specific purposes—promoting HIV testing and PrEP, linking people to antiretroviral therapy and retaining them on treatment, or tuberculosis screening and adherence—on top of strong access platforms for even greater levels of uptake, adherence and retention.

Table 1. Complementary roles of peer educators and peer navigators

Criteria	Peer educator	Peer navigator
Community status?	Always a key population member	May be a key population member ⁱ
HIV status?	Any (disclosure not required)	Usually HIV-positive
Staff?	Usually part-time volunteer who receives remuneration	Usually full-time paid staff
Focus and training?	Supports risk reduction and clinic attendance, prevention and treatment literacy	Supports antiretroviral therapy linkage, adherence, retention, in-depth treatment literacy, viral load testing and enhanced network tracing
Shared confidentiality with key population community member receiving services (HIV status)?	No (unless key population member chooses to)	Required
Ratios (peer role:key populations)?	1:50 to 1:90	1:20 to 1:30
Supervised by whom?	Peer supervisors	Case managers

ⁱThe key population HIV programme may decide that someone other than a key population peer educator would be best suited to be a peer navigator. For example, service beneficiaries may be concerned about disclosure of their HIV status when working with a member of their own key population.



Trusted access platforms have demonstrated optimal outcomes across both HIV prevention and treatment cascades. The main reasons for this can be attributed to the platform aspects themselves: high levels of community trust and participation, with services provided close to where key populations meet and work.



What is needed?

- The foundation is the trusted access platform, with a continuous presence in high-risk venues and promotion of regular medical check-ups. At this level, peer educators simply promote regular clinic visits and do not need to know anyone's HIV status or their reasons for visiting the clinic.
- Peer navigators have a different and separate role from peer educators, including voluntary shared confidentiality with the key populations members they are assisting. Peer navigators who assist with linking to antiretroviral therapy, adherence and retention are themselves living with HIV. An experienced peer educator who is HIV-positive may be recruited and trained as a peer navigator, but the job has a separate scope of work, training needs and supervision support.
- Adherence clubs similarly have shared confidentiality, which is essential to support adherence. This should not be compromised by sharing confidential information with peer educators without consent.



Is it in the budget?

- Peer navigators are hired based on need: salaries, transport allowances, training and supervision. Each programme will need to establish its own case management/clinical supervision procedures and structure—as well as agreements with public health facilities—based on available human resources and services. Nurses or other designated providers can serve as immediate clinical supervisors for navigators.
- Additional and ongoing training on integrating treatment literacy, demand creation for viral loads, undetectable = untransmittable (U = U), data security and confidentiality, and other topics included in the work (e.g., tuberculosis).
- Operational costs for adherence clubs and community adherence groups.

Key resources and examples of guidances and tools

1. Peer navigation for key populations: implementation guide. Washington (DC): FHI 360/LINKAGES; 2017 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-peer-navigation.pdf>, accessed 4 May 2020).
2. Peer navigation training: core modules. FHI 360/LINKAGES (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-peer-navigation-facilitators-guide.pdf>, accessed 4 May 2020).
3. Best practices for integrating peer navigators into HIV models of care. Washington (DC): AIDS United; 2015 (https://www.aidsunited.org/data/files/Site_18/PeerNav_v8.pdf, accessed 4 May 2020).

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7. Improving Adherence and Retention: Community Adherence and Support Groups in Mozambique. In: PEPFAR Solutions Platform (Beta) [Internet]. 18 June 2018. Washington (DC): PEPFAR; c2020 (<https://www.pepfarsolutions.org/solutions/2018/6/18/improving-adherence-retention-community-adherence-and-support-groups-in-mozambique?rq=community>, accessed 4 May 2020).
8. Improving Patient Antiretroviral Therapy Retention through Community Adherence Groups in Zambia. In: PEPFAR Solutions Platform (Beta) [Internet]. 7 February 2018. Washington (DC): PEPFAR; c2020 (<https://www.pepfarsolutions.org/solutions/2018/1/16/decongesting-art-clinics-in-zambia-and-improving-patients-retention-through-community-adherence-groups-mrbtk?rq=community>, accessed 4 May 2020).

Part 2: management for scale and coverage

Key populations programmes built on trusted access platforms rely on programmatic data for continuous planning and monitoring progress.

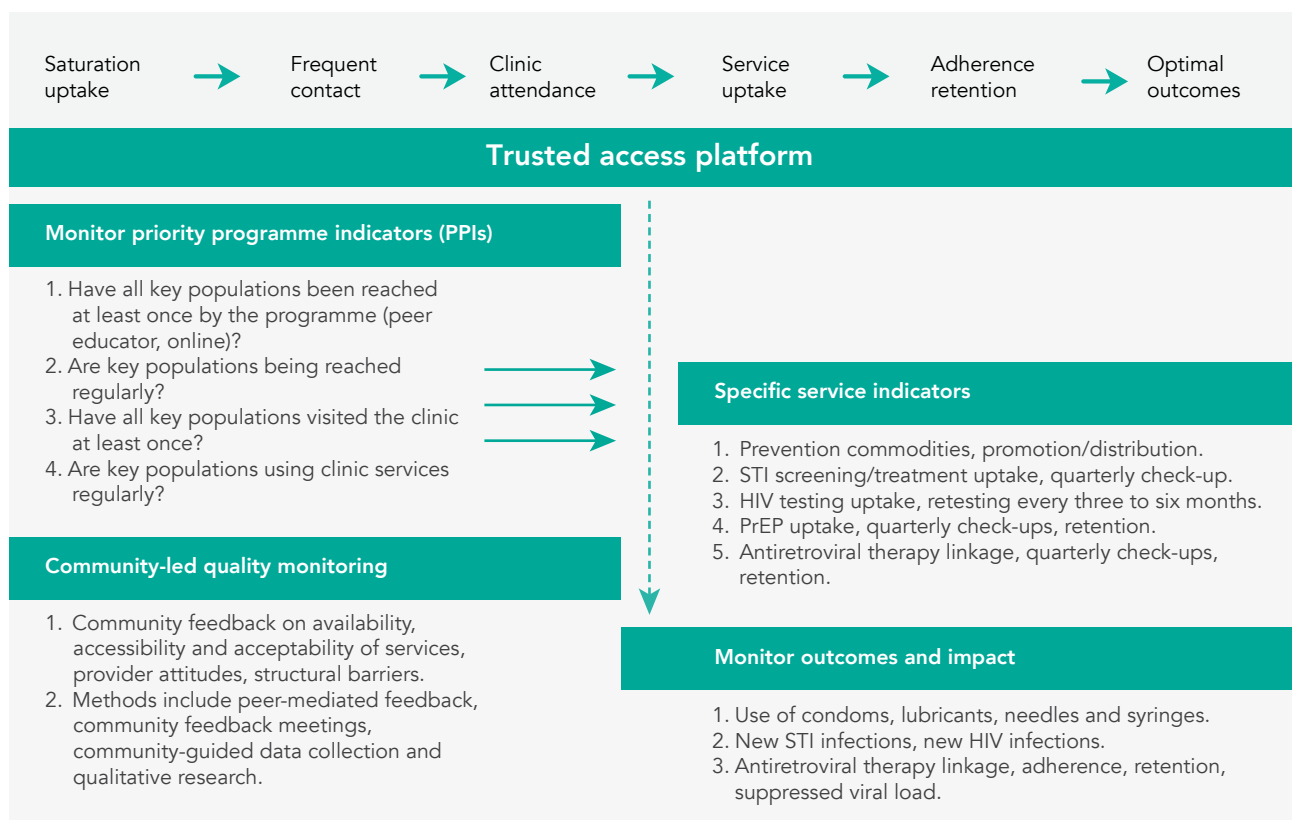
Key populations programmes built on trusted access platforms rely on programmatic data for continuous planning and monitoring progress. This information starts with the most current available estimates of key population locations and population sizes. Mapping with PSE is a critical activity at the central level (see Section 8) in order to plan for scale and coverage, and at the local level (see Section 9) to guide outreach efforts.

Programme monitoring of trusted access platforms (Figure 13) begins with four PPI (see Section 10). These measure the extent to which key populations are being reached in the community and are using clinic services. Targets for these PPI are population-based, using PSE denominators, with progress reviewed monthly. These basic performance data enable reliable monitoring of specific services—including uptake, utilization and retention—using routine service data.

Quality of service provision determines whether services are used, and it requires continuous community input. Several community qualitative monitoring methods—from peer-mediated feedback to community meetings and community-guided quality monitoring—are proposed (see Section 11).

Section 12 looks at whether programmes are making a difference in terms of key outcomes, including use of condoms, lubricants, needles and syringes, and their impact on HIV and STI acquisition and transmission among key populations. Acquisition of new STI and HIV infections can be directly monitored from clinic data, while the estimation of onward transmission involves analysis of the treatment cascade and viral load data, as well as approaches usually outside the programme, such as surveys, modelling and special studies.

Figure 13. Programme monitoring of trusted access platforms



Capacity-building (see Section 13) of both community and programme staff requires planning (community systems strengthening, health systems strengthening and organizational capacity-building), resources, and support mechanisms for training, monitoring, supportive supervision and ensuring community involvement in critical fora.

Section 8: directing efforts where needed (scale and focus)

Pooling existing knowledge at the central level to reach consensus about gaps and priorities facilitates the development of a scale-up plan for staged implementation.

What is it?

For a scaled key population response, it is essential to review what is already known about key populations across the country and to answer these main questions:

1. Where can most key populations be found?
2. Where are existing key populations programmes providing services?
3. What subpopulations of key population communities are not being reached by the programmes?
4. What are the gaps to be filled (in terms of geographic coverage or range of services offered)?
5. How do key populations members want to receive services, and what kinds of services do they want/need?

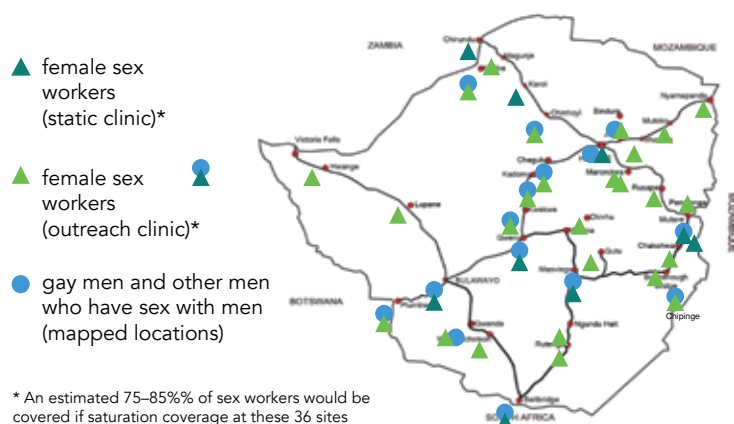
These questions can be answered by mapping and gap analysis. Looking at the questions can be accomplished through a high-level process whereby the national authority (e.g., the Ministry of Health or National AIDS Council) and key informants with knowledge of key populations and experience working with them (e.g., key population representatives, programme staff, community-based or nongovernmental organizations, researchers or donors) conduct a data review and planning meeting. The five questions are answered by reviewing available data and seeking expert opinion from the group.² At this time, gaps in data and data quality can be identified and plans established to address them.

Why is it worth investing in?

Pooling existing knowledge at the central level to reach consensus about gaps and priorities facilitates the development of a scale-up plan for staged implementation in the most important key population locations across the country. The process can be repeated at annual intervals to review new data and refocus planning.

Figure 14. Intervention areas for female sex workers and mapped MSM locations. Sisters with a Voice, Zimbabwe 2017

Additional focused programme components work better when implemented from a trusted access platform, further improving outcomes



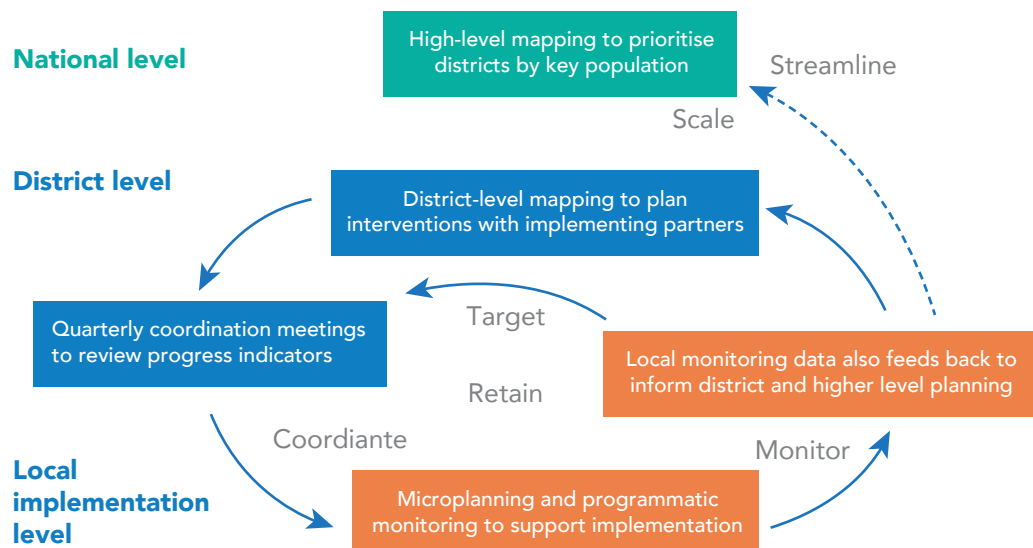
² Maps containing information about the specific locations of key populations (particularly criminalized populations) should be treated as confidential and protected from publication and/or use by law enforcement and national authorities.



What is needed?

- Annual high-level mapping and gap analysis meeting (usually over two days). The main outcome of the meeting is a prioritized, realistically staged scale-up plan for addressing identified gaps. Prioritization and staging take into account population sizes, risk levels and the feasibility of reaching key populations in different locations. They also consider the strengths and weaknesses of existing services. The plan should include a management structure that reflects how implementation will be supported and monitored across the levels, from the local to the intermediate (district) to the central.
- As services for key populations expand beyond the individual community level, nongovernmental and community-based organizations managing the access platform will need wider linkages, a monitoring plan with agreed-upon indicators, training programmes, and mechanisms for data review and shared problem-solving with communities, clinical services and government in the area. Implementing groups may need to change monitoring systems to be able to report on agreed-upon indicators. Unique ID codes (UICs) should be established or harmonized between partners. Figure 15 illustrates a typical information flow between the local implementation and intermediate management levels, with periodic high-level oversight to ensure optimal focus and maintain support.

Figure 15. Example of management information flow between the national, intermediate and local levels



Source: Monitoring guide and toolkit for key population HIV prevention, care, and treatment programs. Durham (NC): FHI 360/LINKAGES Project; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-monitoring-tools.pdf>, accessed 4 May 2020).



Is it in the budget?

- Annual national meetings chaired by national authorities with broad participation, including key population representatives, programme staff, community-based and nongovernmental organizations, researchers and donors.
- Data analysis and data consolidation for meetings (over and above routine programme monitoring at the national level) (staff time, consultant time).
- Planning process for staged scale-up design (staff time, consultant time).
- Programme coordination support for scale-up implementation (staff time).

Key resources and examples of guidances and tools

1. Ensuring compliance with LINKAGES data safety and security checklists. FHI 360/LINKAGES; 2020 (<https://www.fhi360.org/sites/default/files/media/documents/data-safety-guidance.pdf>, accessed 4 May 2020).
2. Unique identifier codes: guidelines for use with key populations. FHI 360/LINKAGES; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-uic-guidance.pdf>, accessed 4 May 2020).
3. Unique identifier code for KP: anonymity, precision and mobility. Accra (Ghana): PACTE-VIH, FHI 360 (Ghana Office) (<https://www.fhi360.org/sites/default/files/media/documents/resource-pacte-vih-identifier-code.pdfm>, accessed 4 May 2020).
4. Key population program implementation guide. Washington (DC): FHI 360/LINKAGES; 2017 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-implementation-guide.pdf>, accessed 4 May 2020).
5. Thompson LH, Bhattacharjee P, Anthony J, Shetye M, Moses S, Blanchard J. A systematic approach to the design and scale-up of targeted interventions for HIV prevention among urban female sex workers. Rajajinagar (India): Karnataka Health Promotion Trust; 2012 (<http://documents.worldbank.org/curated/en/336971468151769158/pdf/NonAsciiFileName0.pdf>, accessed 4 May 2020).
6. Avahan—the India AIDS Initiative: the business of HIV prevention at scale. New Delhi: The Bill & Melinda Gates Foundation; 2008 (http://www.gatesfoundation.org/avahan/Documents/Avahan_HIVPrevention.pdf, accessed 4 May 2020).
7. DiCarlo M, Baer J. Accelerating the implementation and scale-up of comprehensive programs for HIV prevention, diagnosis, treatment and care for key populations. LINKAGES approach and lessons learned. FHI 360/LINKAGES; 2016 (<https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/03/LINKAGES-Accelerating-Implementation-and-Scale-up-of-KP-Programs-FINAL.pdf>, accessed 4 May 2020).

Section 9: knowing your communities

Repeat mapping is important to update outreach planning, PSE and targets with information about new high-risk venues and new key populations.

What is it?

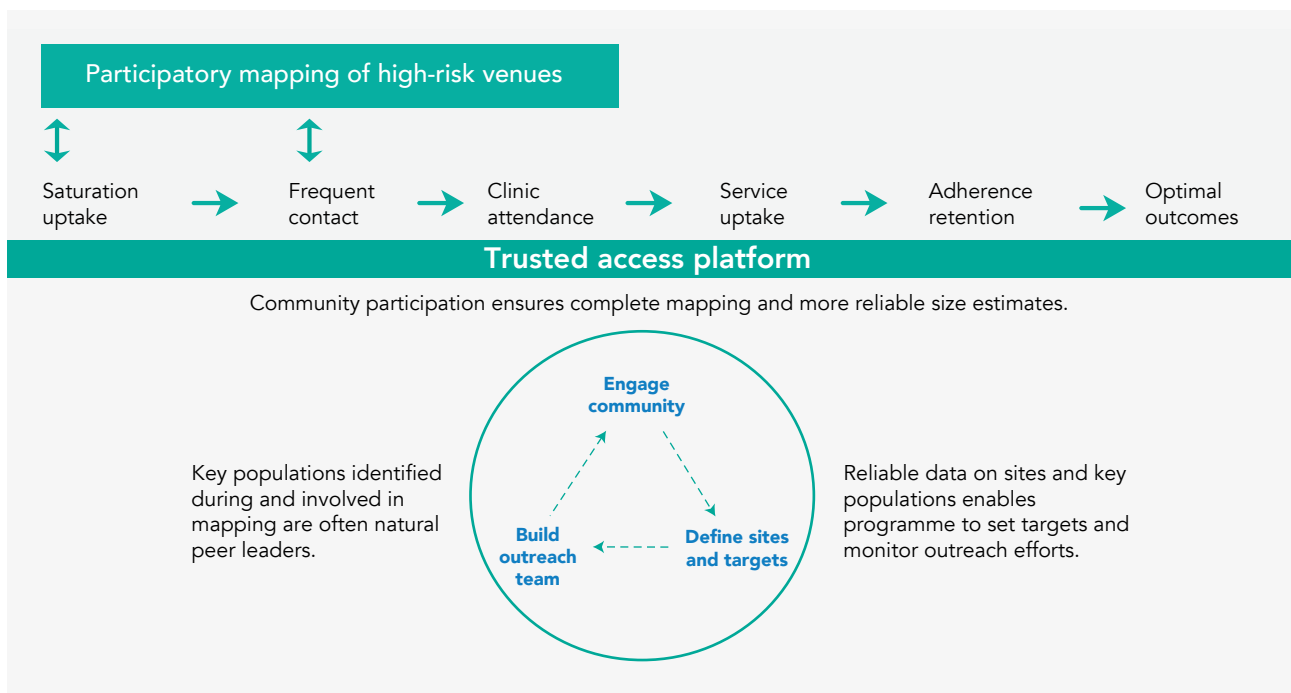
Periodic PPM involves key population communities in the process of identifying high-risk venues and estimating population sizes. It is often the first step in launching key populations programming, and it is a critical opportunity for engaging communities. This early work of mapping high-risk venues is also useful for identifying members of key populations who are influential in their communities and committed to working with them. PPM thus provides needed information, sparks community interest and helps the programme identify members of key populations who can be effective peer educators.

Why is it worth investing in?

PPM has advantages over commissioning an outside organization to perform a formal mapping or size estimation study: (a) the data are more reliable, (b) the cost is lower, (c) the community are engaged in the process, and (d) members of the key population are identified as potential candidates for peer educator training.

Repeat mapping (site validation every six to 12 months) is important to update outreach planning, PSE and targets with information about new high-risk venues and new key populations, as well as any venues that have become inactive or key populations that have moved away. Data from any formal mapping or size estimation studies can be triangulated with data collected through PPM.

Figure 16. Participatory programme mapping provides needed information, sparks community interest and helps the programme identify members of key populations who can be effective peer educators





What is needed?

- PPM involves meeting with key populations from different sites and guiding them to draw simple maps of their sites.
- These maps identify high-risk venues, key roads and landmarks, and they include rough estimates of the number of key populations found at each spot.
- The second stage, high-risk venue validation, involves the outreach team and key population members in walk-around visits to high-risk venues for observation and informal discussions with key population members and stakeholders. This helps to validate estimated numbers, peak times and other details.



Is it in the budget?

- Several days per site for participatory mapping, and then several hours per high-risk venue for a walk-around validation.
- Repeat site validation and PSE updates every six to 12 months. This is often done by existing outreach teams, remunerated peers and supervisors, with support from data managers.

Key resources and examples of guidances and tools

1. The Global Fund, WHO, UNDP, PEPFAR, University of Manitoba, UNAIDS et al. Using programmatic mapping to improve program access and coverage for key populations: guidelines for countries. 2016 (<https://hivpreventioncoalition.unaids.org/resource/using-programmatic-mapping-to-improve-program-access-and-coverage-for-key-populations-guidelines-for-countries/>, accessed 6 August 2020).
2. Emmanuel F, Persaud N, Weir SS, Bhattacharjee P, Isac S. Programmatic mapping: providing evidence for high impact HIV prevention programs for female sex workers. *JMIR Public Health Surveill.* 2019;5(2):e12636 (<https://publichealth.jmir.org/2019/2/e12636/pdf>, accessed 4 May 2020).
3. Cunningham M, Lamois P, Mapala Y, Inglis A. Using participatory mapping to assess service catchment and coverage: guidance from the Iringa Participatory Mapping Exercise. *MEASURE Evaluation*; 2014 (<https://www.measureevaluation.org/resources/publications/sr-14-109>, accessed 4 May 2020).
4. Priorities for Local AIDS Control Efforts (PLACE) Tool Kit. In: *MEASURE Evaluation* [Internet]. Chapel Hill (NC): MEASURE Evaluation; c2020 (<https://www.measureevaluation.org/resources/tools/hiv-aids/place>, accessed 4 May 2020).
5. PLACE: priorities for local AIDS control efforts. Sample protocol. Chapel Hill (NC): MEASURE Evaluation, University of North Carolina; 2019.

6. ** Virtual Priorities for Local AIDS Control Efforts (PLACE): protocol for a study of social media sites. Chapel Hill (NC): MEASURE Evaluation, University of North Carolina; 2019 (<https://www.measureevaluation.org/resources/publications/tl-19-56>, accessed 4 May 2020).
7. ** Social media mapping – for planning online HIV outreach and service delivery. LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-media-mapping.pdf>, accessed 4 May 2020).
8. ** Quick online surveys – for planning online HIV outreach and service delivery. LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-surveys-planning-online-outreach.pdf>, accessed 4 May 2020).

Section 10: monitoring performance (for trusted access platforms)

PPIs show how well the key population platform is working to reach key populations and link them to clinical services.

What is it?

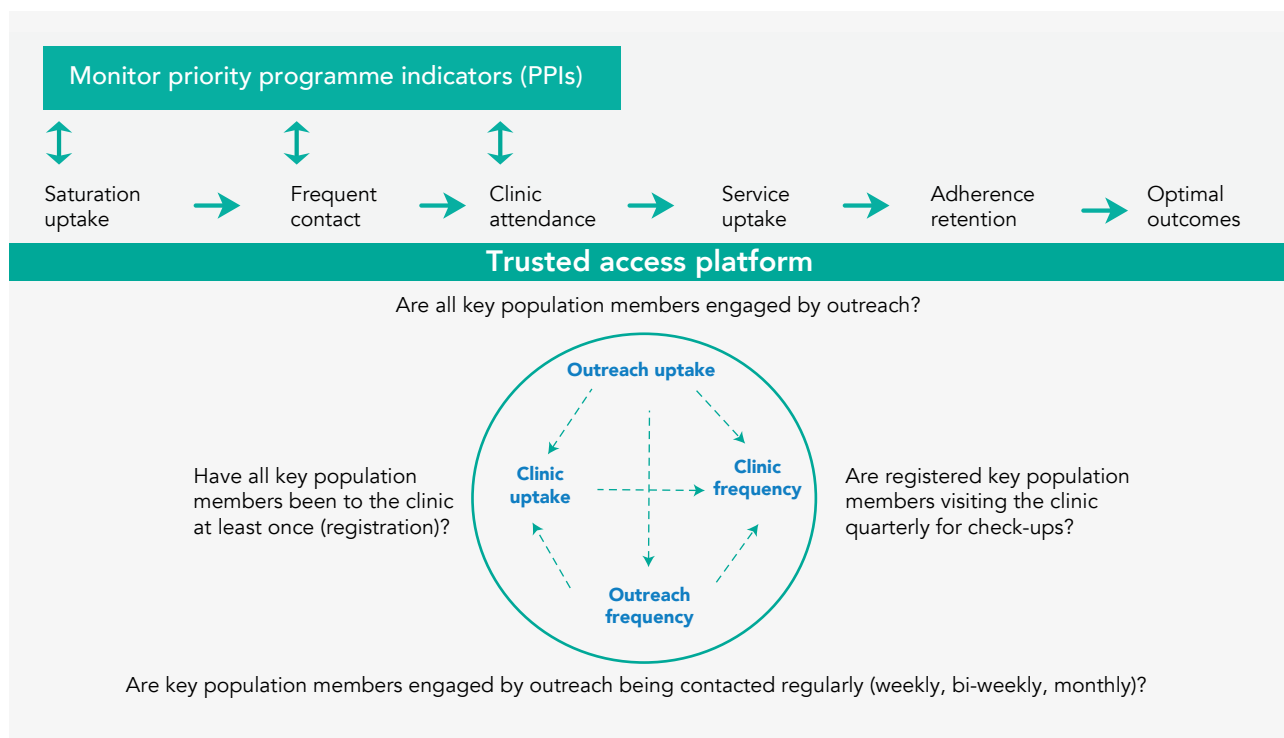
Monitoring progress for a trusted access platform begins with four main questions related to a given population:

1. Have all key population members been reached at least once by a peer educator (outreach uptake)?
2. Are key populations being reached regularly (outreach frequency)?
3. Have all key populations visited the clinic at least once (clinic uptake and registration)?
4. Are key populations using clinic services regularly (clinic frequency)?

These key questions, or PPIs, show how well the key population platform is working to reach key populations and link them to clinical services.³ PPI progress is monitored monthly against actual population targets based on local mapping and PSE. Uptake targets for outreach and clinic registration use the PSE as denominator, which is reviewed and updated every three to six months to include new key populations and high-risk venues (and to deactivate those no longer active). Targets for outreach and clinic frequency are set by the programme,

³ The next two monitoring sections address service quality (Section 11) and outcomes and impact (Section 12). Other indicators (not covered here) measure the use of specific services like HIV testing or STI screening, distribution of prevention commodities, HIV testing, and linkage to care and adherence.

Figure 17. Four key questions show how well the key population platform is working



Without reliable data on key population sizes and the proportions using clinic services and being reached through outreach, it is difficult to make sense of data on specific service usage or to identify gaps.

generally one to four times monthly for outreach contacts (depending on risk) and quarterly for clinic visits.⁴ Targets for virtual outreach will be different.

Why is it worth investing in?

Monitoring platform performance is only the first step in monitoring key population programmes. But these data are essential for understanding how well the programme is performing on other indicators and targets, such as: condoms, lubricant and needle–syringe distribution; HIV testing; PrEP uptake; OST uptake; and successful linkage to care. Without reliable data on key population sizes and the proportions using clinic services and being reached through outreach, it is difficult

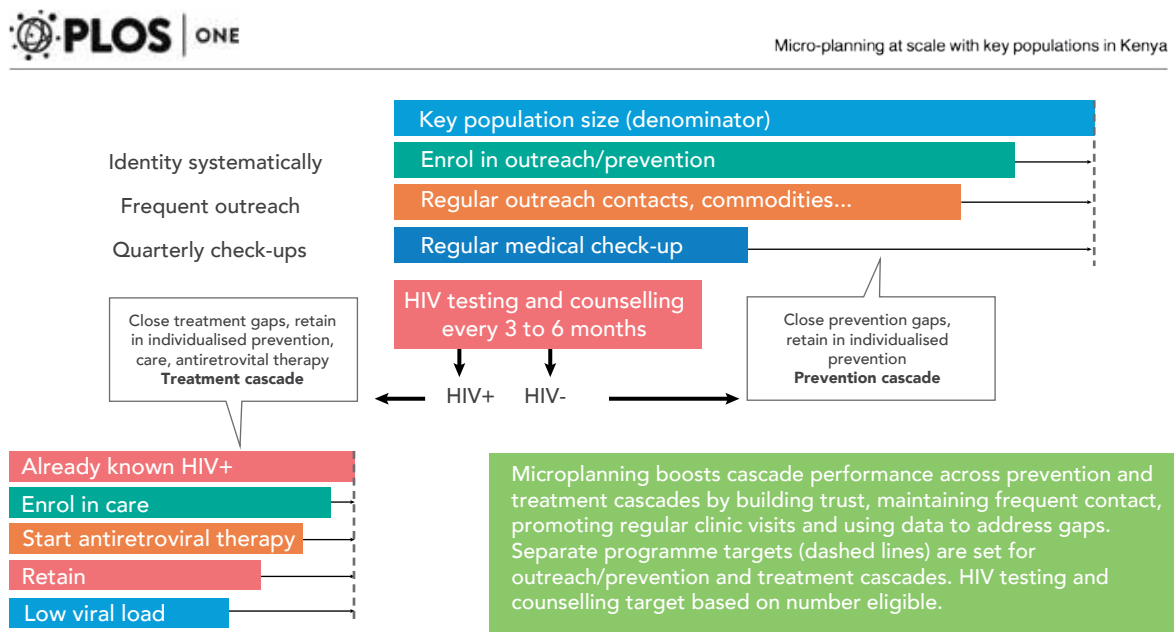
⁴ Specific services should also be monitored in the context of the population (PSE) and PPIs. If only two thirds of the estimated members of key populations have been reached, for example—and only half of them have used the clinic—HIV testing uptake will be low. Improving platform performance for outreach and clinic attendance will result in higher testing rates.

to make sense of data on specific service usage or to identify gaps.

Most importantly, platform indicators are used to monitor overall progress, identify problems and manage programmes for continuous improvement. They also are indicative of community trust and participation. Partial outreach uptake or declining clinic visits can suggest that key populations are avoiding peer educators or are dissatisfied with services for some reason, inspiring further investigation (also see Section 11 on community quality monitoring).

Platform aims of identifying key populations systematically—followed by frequent outreach and regular clinic check-ups—are illustrated in the upper part of Figure 18 (below), including progress made towards reaching identified targets and gaps. Targets for specific services like HIV testing and antiretroviral therapy linkage are then set according to other indicators and eligibility criteria.

Figure 18. Example of priority indicators as entry point for cascade analysis



Source: Bhattacharjee P, Musyoki H, Prakash R, Malaba S, Dallabetta G, Wheeler T et al. Micro-planning at scale with key populations in Kenya: optimising peer educator ratios for programme outreach and HIV/STI service utilization. PLoS One. 2018;13(11):e0205056 (<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205056>, accessed 4 May 2020).



What is needed?

- The monitoring of trusted access platforms (as described above) assumes mapping of high-risk venues with PSE estimates. There also needs to be methods in place (such as UICs) to identify and monitor outreach and service uptake and use among individual key population members.
- The management plan should reflect the planned scale and standards of the programme, often summarized as a common minimum programme with clear targets. Management starts at the local level with frequent (weekly) review of peer educator work with the peer supervisor. The peer supervisor reviews the previous week's work, discusses problems, collects/enters data, and then assists with planning the work for the next week. Similarly, the peer navigator discusses work and problems with case management supervisors, reviews data and assists with planning subsequent work.
- Dashboard reviews of PPIs for basic coverage and engagement, HIV testing, and antiretroviral therapy linkage and retention take place monthly by site (and at the intermediate district and central programme levels) with active problem-solving. Higher level reviews involving other interested partners or stakeholders may be organized quarterly or annually, with additional areas of focus (such as updating high-level mapping for scale).



Is it in the budget?

- Mapping and size estimation for PSE (see Section 9).
- Meeting/process to plan UIC (if not already operational) for key population programmes in the area (also includes related training, implementation and IT support).
- Weekly supportive supervision visits of peer educators by peer supervisors and peer navigators with case managers.
- Data entry, cleaning and analysis to produce PPI dashboards and prevention/care cascades.
- Monthly dashboard reviews by respective outreach teams (by site and at the intermediate district and central programme levels) with active problem-solving.
- Regular dashboard reviews with outreach and clinic teams, government and programme managers (local level: monthly; intermediate district: quarterly; and central programme level: semi-annually).

Key resources and examples of guidances and tools

1. Monitoring guide and toolkit for key population HIV prevention, care, and treatment programs. Durham (NC): FHI 360/LINKAGES Project; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-monitoring-tools.pdf>, accessed 4 May 2020).
2. Key population data collection tools in Kenya: reference manual. Nairobi: National AIDS and STI Control Programme (Kenya); 2014 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/03/compressed_Kenya-KP-TOOLS-REFERENCE-GUIDE.compressed.pdf, accessed 4 May 2020).
3. Bhattacharjee P, Musyoki HK, Becker M, Musimbi J, Kaosa S, Kioko J et al. HIV prevention programme cascades: insights from HIV programme monitoring for female sex workers in Kenya. *J Int AIDS Soc.* 2019;22(4):22e25311 (<https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25311>, accessed 4 May 2020).
4. Use it or lose it: how Avahan used data to shape its HIV prevention efforts in India. New Delhi: The Bill & Melinda Gates Foundation; 2008 (http://www.gatesfoundation.org/avahan/Documents/Avahan_UseItOrLooselt.pdf, accessed 4 May 2020).

Section 11: community-led quality monitoring

What is it?

Regular monitoring of the quality of interventions and services offered can be done effectively with and by community members. Two common ways are by:

- Arranging community feedback and planning meetings.
- Checking in frequently with peer educators and peer navigators about community perceptions.

Additionally, community-led monitoring of service quality and accessibility—such as in government treatment services—should be supported by the programme and incorporated into routine data reviews and problem-solving meetings. Reporting links from the community to national key population groups should be established in such a way that shared problem-solving with the government and advocacy at the national level can be based on data from the programme level. As programmes evolve and move towards community ownership, monitoring quality should be integrated into community decision-making processes.

Quality monitoring through peer networks can be organized in several ways:

- One approach is to channel questions through peer educators and peer navigators. Questions can be general (“What do you like/dislike about the services?”) or directed towards resolving specific problems (“We see that fewer people are coming to clinic; is there a problem?”).
- Community feedback meetings with attention to programme quality and related referral services—including availability, accessibility and acceptability of services, provider

attitudes, structural barriers, or preferences regarding needles, syringes, condoms and lubricants—can be organized at the drop-in centre or other safe spaces on a regular basis (initially monthly to quarterly, becoming less frequent as the programme matures).

- Community feedback can be organized to be more routine by establishing assessments of service quality by community members using checklists. These checklists can include issues of concern to the programme, but also questions/issues of concern to the community.
- In some programmes, peer educators complete quarterly updates, which include information about key populations at their location (e.g., the number of newcomers and the number who were inactive/lost to follow-up in the last quarter), risk assessment, participation in the self-help group and so on. These quarterly updates also provide opportunities to ask a few qualitative questions about services.
- In some cases, more structured qualitative methods—such as focus group discussions or key informant interviews—can be organized to explore one or more important issues in detail.
- Community-led monitoring, when the monitoring is independent of the community-based or nongovernmental organization implementing the programmes, has several advantages:
 - Community-led monitoring involves the wider community in services and builds community ownership of quality and outcomes.

Reporting links from the community to national key population groups should be established in such a way that shared problem-solving with the government and advocacy at the national level can be based on data from the programme level.

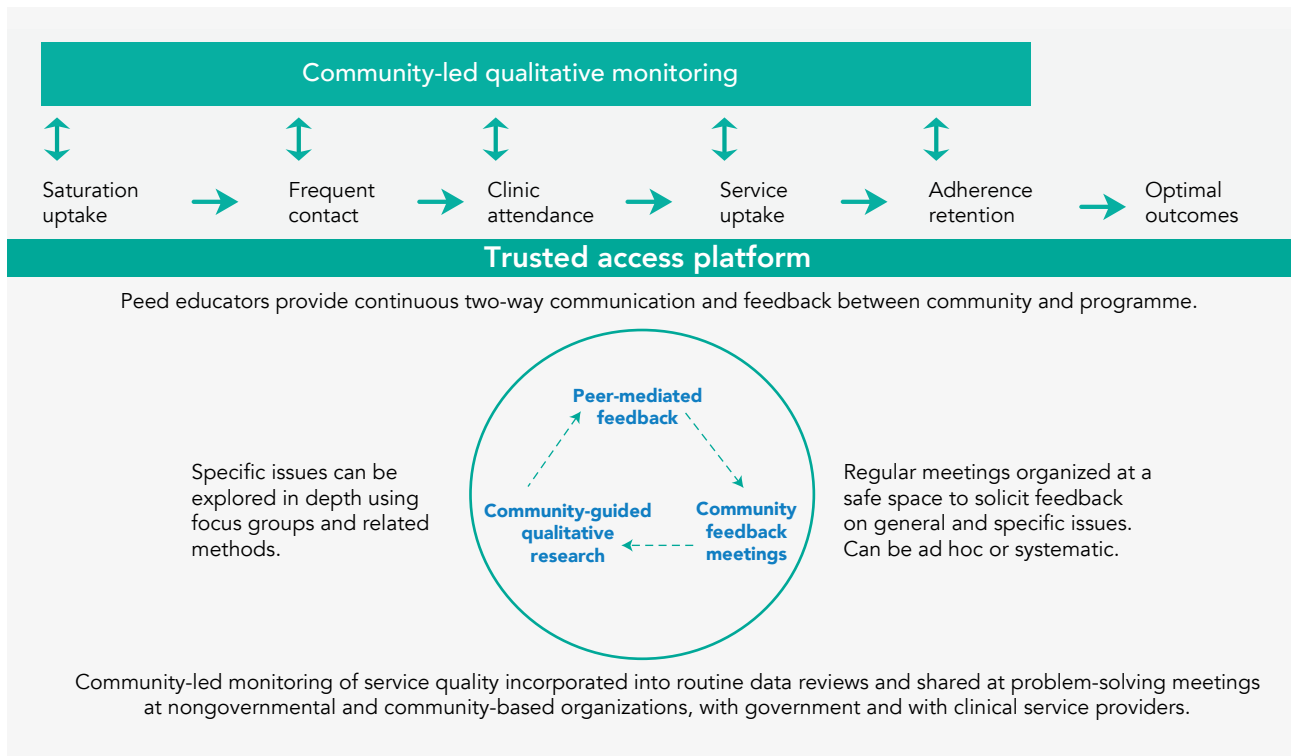
- It overcomes issues where peer educators and peer navigators might be reluctant to share negative feedback with health systems. For instance, this might occur because the health system is their employer or because they receive their own health services in the same health system.

Note: There needs to be a rigorous system in place to protect peer educators, peer navigators and clients against retaliation for reporting negative aspects of service delivery.

Why is it worth investing in?

It is critical for key populations programmes and treatment programmes to understand and respond to community needs and issues. Early investment in community meetings and qualitative monitoring through peer networks associated with an action plan for resolution builds trust and participation in the programme and improves the quality of services.

Figure 19. Regular monitoring of intervention quality and services can be effectively done with and by community members



Early investment in community meetings and qualitative monitoring through peer networks associated with an action plan for resolution builds trust and participation in the programme and improves the quality of services.



What is needed?

- A plan for community-led monitoring of service quality using peer networks, community feedback meetings, systematic community data collection, qualitative research or similar methods.
- Negotiation with clinical services and government offices regarding community data collection and input into regular meetings.
- Support for data collection (if is not part of routine outreach).
- Reporting links with national key population advocacy groups.



Is it in the budget?

- Support for community feedback meetings.
- Support for community involvement in problem-solving meetings with referral services and government.
- Community-led monitoring of programme/referral services:
 - Technical and financial support for communities for routine monitoring.
 - Education of community monitors on the elements of international standards for care and services, data collection methods and information gathering.
 - Tools tested, database established and interpretation support/training provided.
 - Linkage to national key population network.
- Support for other qualitative methods with technical assistance (e.g., focus groups, key informant interviews, exit interviews and mystery client).
- Electronic devices and software subscriptions for electronic client feedback systems.
- Financial and technical support for outside community members to monitor quality.

Key resources and examples of guidances and tools

1. Community-led monitoring brief. ITPC Global; 2020 (http://itpcglobal.org/wp-content/uploads/2020/02/Community-Led-Monitoring-Brief_full.pdf, accessed 4 May 2020).
2. Understanding gaps in the HIV care continuum in 11 West African countries: findings from ITPC's Regional Community Treatment Observatory. ITPC Global; 2019 (<http://itpcglobal.org/wp-content/uploads/2019/10/RCTO-Regional-Fact-Sheet-June-2019.pdf>, accessed 4 May 2020).
3. Sex workers' experiences of stock-outs of HIV/STI commodities and treatments. Edinburgh and Gaborone (Botswana): NSWP and ITPC; 2018 (<http://itpcglobal.org/wp-content/uploads/2018/12/ITPC-NSWP-Briefing-Paper-Sex-Workers-Experiences-of-Stock-outs.pdf>, accessed 4 May 2020).

4. Killingo BM, Tara TB, Mosime WM. Community-driven demand creation for the use of routine viral load testing: a model to scale up routine viral load testing. *J Int AIDS Soc.* 2017;20(S7):e25009 (<http://itpcglobal.org/wp-content/uploads/2017/12/Killingo-Community-driven-demand-creation-for-the-use-of-routine-viralload-testing-a-model-to-scale-up-routine-viral-load-testing-2017.pdf>, accessed 4 May 2020).
5. Technical brief: community systems strengthening. Geneva: The Global Fund; 2019 (https://www.theglobalfund.org/media/4790/core_communitysystems_technicalbrief_en.pdf, accessed 4 May 2020).
6. Cornish F, Ghosh R. The necessary contradictions of 'community-led' health promotion: a case study of HIV prevention in an Indian red light district. *Soc Sci Med.* 2007;64(2):496-507 (http://eprints.lse.ac.uk/47785/1/Libfile_repository_Content_Cornish%2C%20F_The%20necessary%20contradictions_The%20necessary%20contradictions%20%28Isero%29.pdf, accessed 4 May 2020).
7. Postnov AV. Manual on the "secret client" methodology for assessing the quality of services related to HIV treatment and prevention among MSM and trans people. Tallinn (Estonia): Eurasian Coalition on Male Health (ECOM); 2018 (<https://docs.google.com/viewerng/viewer?url=https://ecom.ngo/wp-content/uploads/2018/09/tajnyj-eng.pdf&hl=ru>, accessed 4 May 2020).
8. ** LINK — electronic client feedback systems for HIV programs. LINKAGES; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-electronic-client-feedback-systems.pdf>, accessed 4 May 2020).

Section 12: monitoring selected outcomes

It is important to know whether programmes are moving towards key outcome objectives.

What is it?

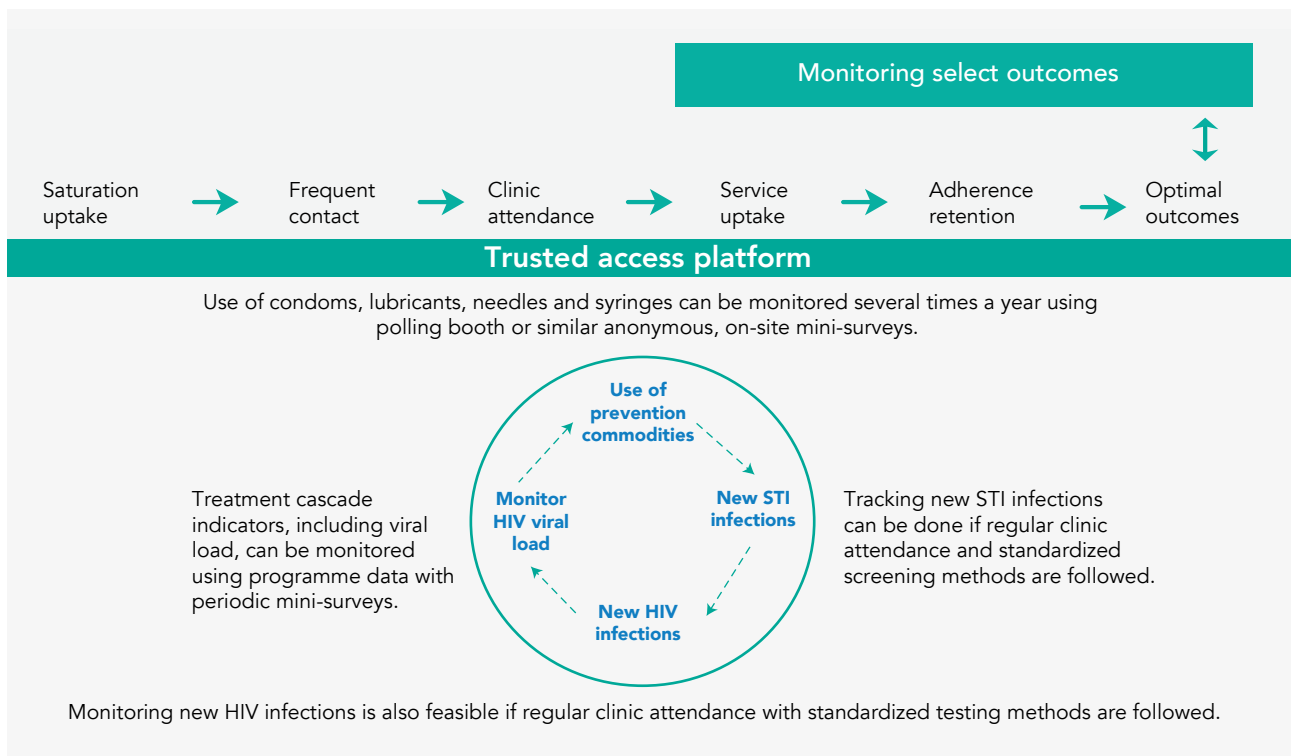
In addition to monitoring platform indicators, progress towards scaled uptake, use of specific services, and the perceived quality and acceptability of those services by the community, key population programmes should also try to assess certain outcomes and impact. To some extent, this can be done by using programme data coming from trusted access platforms. It is important to know whether programmes are moving towards key outcome objectives—including the actual use of condoms, lubricants, needles, syringes, PrEP, OST, HIV testing and antiretroviral therapy—and their impact

on key population HIV/STI acquisition (see Figures 20 and 21). Some of these outcomes can be monitored using routine programme data, and all can be obtained through simple survey methods.

Routine programme data from clinics include:

- Trends of new STI infections diagnosed (from systematic screening with high uptake).
- Trends of new HIV infections diagnosed (from systematic, regular HIV testing and counselling among previously HIV-negative individuals with high uptake).

Figure 20. Measuring outcomes using routine programmatic data from robust access platforms offers several advantages



- PrEP uptake and adherence.
- Antiretroviral therapy uptake and adherence and viral loads.⁵

Routine programmatic survey methods that are feasible include polling booth or computer-assisted methods conducted either in clinics or the community to assess condom use, experience with violence, HIV status, treatment adherence and so on. These can be validated with less frequent, more rigorous population-based surveys (every three to four years).⁶

Measuring outcomes using routine programmatic data from robust access platforms offers several important advantages over infrequent surveys.

⁵ Monitoring new STIs and HIV infections in this way requires confidentiality safeguards, which is more feasible in programme-linked clinics and more challenging with outside referrals. Monitoring antiretroviral therapy use, adherence and viral load outcomes currently requires working closely with clinical services, which is the role of the peer navigator.

⁶ Integrated biological and behavioural survey or assessment (IBBS or IBBA).

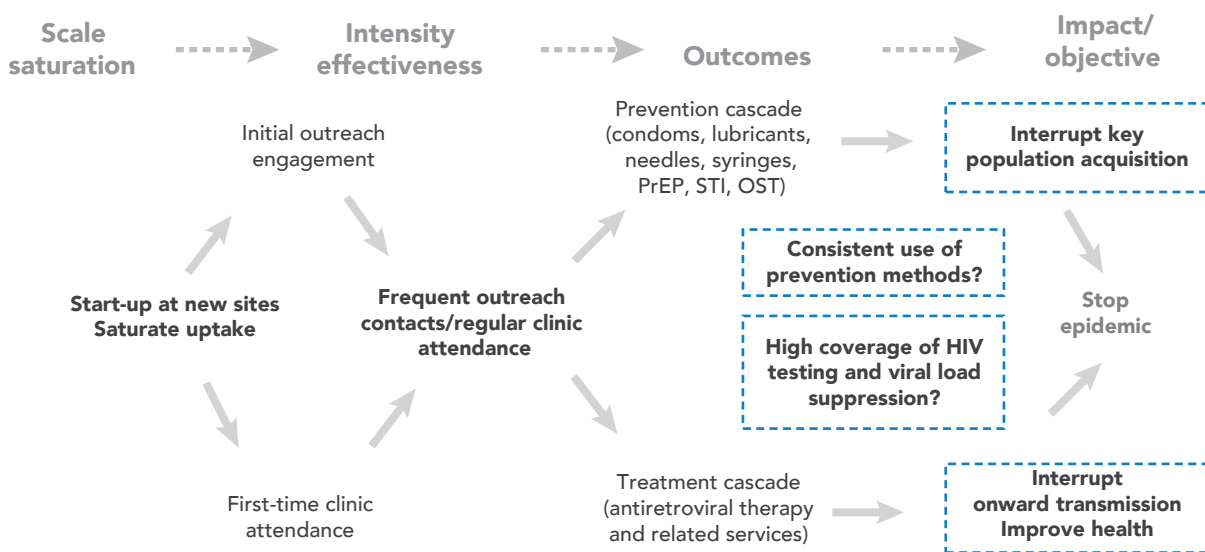
Why is it worth investing in?

Measuring outcomes using routine programmatic data from robust access platforms offers several important advantages over infrequent surveys: data reflect what is happening across all intervention communities rather than a few sample sites, and trends can be followed with monthly updates (rather than several years passing between survey rounds). When triangulated with platform indicators of outreach and service use, programmes can continuously assess progress toward outcome targets and make adjustments where needed.

Mini-surveys using polling booth or similar methods that are conducted at least once a year at all sites allow the collection of select behavioural data: condom, lubricant, needle and syringe use; HIV testing frequency; OST use; PrEP use; antiretroviral therapy linkage and adherence; experiences with violence; and other important outcomes. These surveys can also be triangulated with programmatic data.

Figure 21. Key population programme logic model, including desired outcomes and impact

Where can programmes look for evidence of impact?





What is needed?

- Robust, routine programming monitoring system with UICs, with core indicators standardized across key population programmes and reported upward for a country-wide view of progress and gaps.
- Routine voluntary STI screening for monitoring STI trends with defined diagnostic criteria (syndromic, clinical or aetiologic) and for HIV testing and counselling for monitoring trends of new HIV infections, UICs, and methods to filter duplication, including multiple HIV tests per individual, and tracking information on individuals as they move outside of nongovernmental and community-based service catchment areas.
- Polling booth or computer-assisted survey methods for assessing progress.



Is it in the budget?

- Robust monitoring system with peer-beneficiary interaction data, coupled with clinical data that are aggregated upwards (after being used and acted upon locally).
- Training of peers, peer supervisors, peer navigators, project-supported case managers and project-supported clinical staff in data forms, data entry, data management and security.
- Project staff responsible for aggregated data.
- Design, training, procurement of necessary supplies and implementation of mini-surveys with the community.
- Related information technology and analysis support.

Key resources and examples of guidances and tools

1. Monitoring guide and toolkit for key population HIV prevention, care, and treatment programs. Durham (NC): FHI 360/LINKAGES Project; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-monitoring-tools.pdf>, accessed 4 May 2020).
2. Key population data collection tools in Kenya: reference manual. Nairobi: National AIDS and STI Control Programme (Kenya); 2014 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/03/compressed_Kenya-KP-TOOLS-REFERENCE-GUIDE.compressed.pdf, accessed 4 May 2020).
3. Bhattacharjee P, Musyoki HK, Becker M, Musimbi J, Kaosa S, Kioko J et al. HIV prevention programme cascades: insights from HIV programme monitoring for female sex workers in Kenya. *J Int AIDS Soc.* 2019;22(4):22e25311(<https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25311>, accessed 4 May 2020).
4. Use it or lose it: how Avahan used data to shape its HIV prevention efforts in India. New Delhi: The Bill & Melinda Gates Foundation; 2008 (http://www.gatesfoundation.org/avahan/Documents/Avahan_UseltOrLooselt.pdf, accessed 4 May 2020).

Section 13: capacity-building

Community empowerment is a progressive process arising from well-implemented key population programmes that can be facilitated by a range of community systems strengthening activities.

What is it?

Key populations programmes need capacity-building plans for community and staff that are appropriate for planned services. Staff development requires a capacity-building mechanism or technical capacity unit that includes training and supportive supervision based on standards closely linked to programme monitoring.

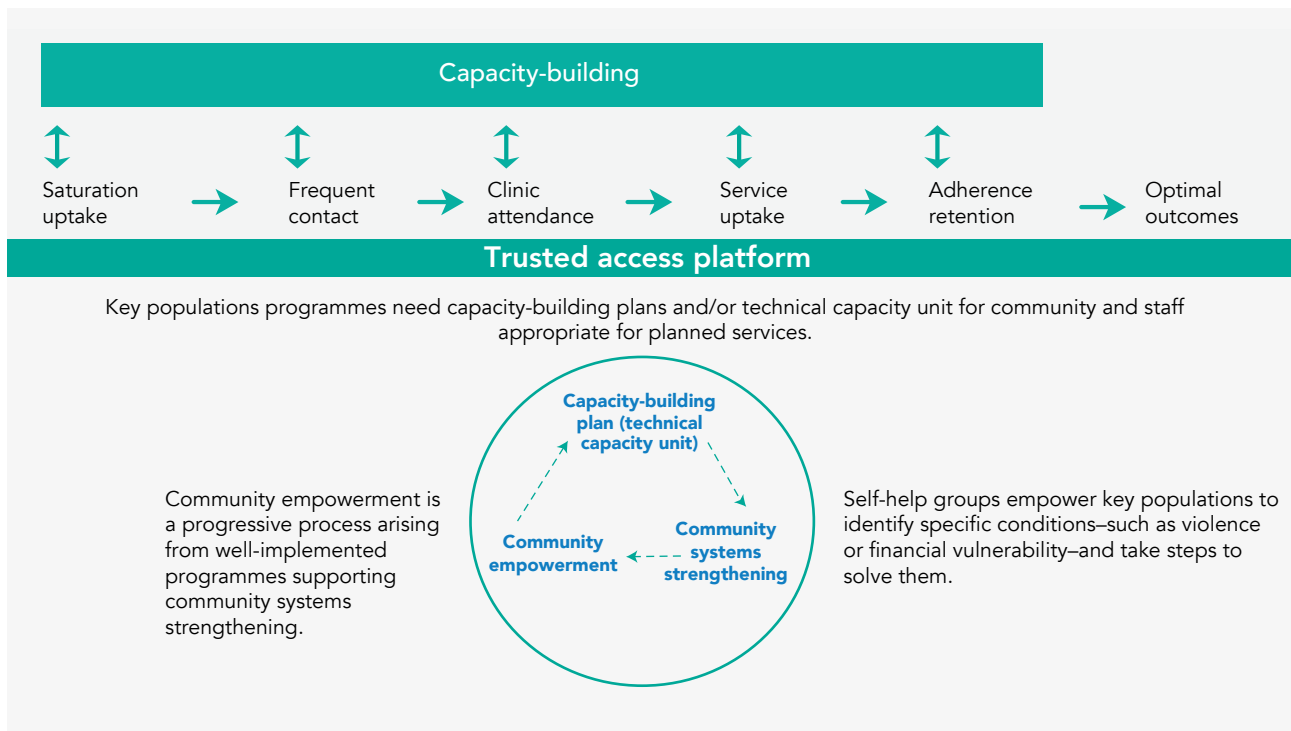
Community empowerment is a progressive process arising from well-implemented key population programmes that can be facilitated by a range of community systems strengthening activities. Self-help groups are an example of community systems strengthening that

empowers key populations to identify specific conditions—such as violence or financial vulnerability—and take steps to solve them. As communities become organized, strengthening organizational and institutional capacity is an important component of sustainability.

Why is it worth investing in?

Building capacity of community and staff facilitates and strengthens programme implementation while building trust and empowering communities to play a leading role. Strengthening organizational and institutional capacity is an important component of sustainability.

Figure 22. Building capacity of community and programme staff





What is needed?

- A capacity-building plan for community and staff appropriate for planned services.
- Provision of regular support through a technical capacity unit or similar mechanism.
- Articulated and planned progression pathway for key populations to assume increasing responsibilities in the planning, implementation and review of programmes with associated training plans.
- Self-help groups and community systems strengthening at the local level to promote critical enablers, address conditions identified by key populations and support community empowerment.
- Organizational and institutional capacity-building plan.



Is it in the budget?

- Capacity-building needs assessment and planning process.
- Technical capacity unit or similar capacity-building mechanism.
- Community systems strengthening plan and activities.
- Organizational and institutional capacity-strengthening plan and activities.
- Adaptation of existing of capacity-building materials or development of new ones.
- Support for establishment of self-help groups or community committees.
- Support for communities to engage fora, processes and decision-making bodies at the local, regional and national levels.
- Support for communities to link to national key populations advocacy groups.

Key resources and examples of guidances and tools

1. Integrated Technical Organizational Capacity Assessment (ITOCA) and action planning: facilitators guide. Washington (DC): PACT; 2016 (<https://www.fhi360.org/sites/default/files/media/documents/linkages-facilitators-guide-itoca.pdf>, accessed 4 May 2020).
2. An integrated approach to institutional strengthening of key population CBOs in the Kingdom of Eswatini. Washington (DC): PACT; 2019 (<https://www.pactworld.org/library/integrated-approach-institutional-strengthening-key-population-cbos-kingdom-eswatini>, accessed 4 May 2020).
3. CBO management committee training manual series: basic and advanced. New Delhi: FHI 360 (India Country Office); 2012 (<https://www.fhi360.org/sites/default/files/media/documents/CBO%20Management%20Committee%20Training%20Manual%20Series%20Basic%20and%20Advanced.pdf>, accessed 4 May 2020).
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Annexes

Annex A. Consolidated table of budget considerations for a trusted access platform

The following summarizes and consolidates operational budget recommendations for the main recommended trusted platform areas described in the document: continuous venue presence (Sections 1 through 4), prevention and clinical support (Sections 5 through 7) and management (Sections 8 through 13). These are meant to be prompts for consideration as the programme is designed and budgeted. Notes on consideration for virtual/online outreach are highlighted in pink and are in Table 3 in this annex.

Table 2. Budget considerations for trusted access platforms

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
Outreach staff and supervisors			
<p>Note: This budget consideration document is presented for in-person programming. Depending on the goals of the specific virtual outreach, peer educators and peer navigators will still be needed to develop relationships online with beneficiaries, and they will still need supportive supervision, mentoring and ongoing training and skills-building. This online work requires settings and procedures for convenient and private follow-up and re-engagement, peers skilled in using the technology and appropriate equipment. Peer educators and peer navigators may do both online work and field work.</p>			
Peer educators			
<p>Peer educator hiring</p> <p>Based on population size estimate at a ratio of roughly 1:50 (for further details, see notes).</p> <ul style="list-style-type: none"> Remuneration for peers. Reimbursement for out-of-pocket expenses (e.g., airtime and travel). Additional costs associated with outreach work depending on project design (e.g., electronic tablets/data collection phones, bicycles, cases to carry forms). Costs associated with ensuring safety and security of outreach workers (e.g., badges, uniforms, phones and safety plans). 	Part 1: Section 1 through Section 4	<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p>Interventions, depending on the context, may be included under:</p> <ul style="list-style-type: none"> Condom/lubricant programming. Pre-exposure prophylaxis (PrEP). Behaviour change communication. Community empowerment. Sexually transmitted infections (STIs). Harm reduction. 	<p>To estimate the peer:community ratio, consider:</p> <ul style="list-style-type: none"> Time of work for peers (approximately four hours per day). Days of work for peers (five days per week). Estimated number of contacts they can meet in one day. Estimated number of individuals followed by key population members to be met weekly, bi-monthly or monthly. Number of days required for data review and planning meetings with peer supervisor. <p>Note: This estimate is for basic peer outreach as described here, not peer navigators (who are covered below). It may be lower or higher depending on the time and difficulty in reaching individuals and how much outreach is performed virtually.</p>

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<ul style="list-style-type: none"> ▪ On-boarding training for new peers. <ul style="list-style-type: none"> — Development/adaptation of existing curricula, including microplanning and programmatic mapping. — Implementation of trainings. — On-the-job training. ▪ Refresher trainings and new skills training. <ul style="list-style-type: none"> — Development/adaptation of existing curricula. — Implementation of trainings. 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p>	<p>On-boarding training</p> <p>Given peer educator turnover, estimate trainings occur twice per year for new hires.</p> <p>Refresher trainings</p> <p>Refresher trainings every six months for existing peers. These can potentially include:</p> <ul style="list-style-type: none"> ▪ Correct/reinforce implementation issues seen since the previous training. ▪ Introduce changes/additions given the evolving context, HIV prevention and treatment developments, and strengthened community groups. ▪ Improve knowledge of HIV treatment and prevention and other diseases relevant to the community (e.g., hepatitis C, tuberculosis and STIs) to help improve community literacy around the issues. ▪ Share successful approaches seen within the nongovernmental and community-based interventions or from elsewhere.
<p>Peer data collection materials developed, tested and printed</p> <ul style="list-style-type: none"> ▪ Microplanning tools and consolidation forms developed. ▪ Forms printed/electronic tablets programmed. ▪ Manuals/field educational material developed and printed for peer educators. 		<p>RSSH:</p> <p><i>Module:</i> Health management information systems and M&E</p>	<ul style="list-style-type: none"> ▪ Microplanning tools and other data collection forms should be developed/adapted and tested. ▪ Training on data collection methods used should be included in the on-boarding and refresher training noted above. Quality of data collection will improve with regular supervision.
Peer supervisors			
<p>Peer supervisor hiring</p> <p>Supervise peer educators based at a ratio of 1:5 to 1:8.</p> <ul style="list-style-type: none"> ▪ Salary. ▪ Reimbursement for out-of-pocket expenses (e.g., airtime and travel). ▪ Additional costs associated with supervisory duties, depending on project design (e.g., electronic tablets/data consolidation forms or cases to carry forms). ▪ Costs associated with ensuring safety and security of outreach workers (e.g., badges, uniforms, phones and safety plans). 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p>	<p>Peer supervisor responsibilities are to do the following:</p> <ul style="list-style-type: none"> ▪ Oversee peer educators. ▪ Meet weekly for one-on-one sessions to review data, participate in shared problem-solving with peer educator, and plan subsequent work. ▪ Collect and aggregate/consolidate data from peer educators if paper-based forms are used. ▪ Attend monthly meetings of all peer educators and peer supervisors. ▪ Participate in shared problem-solving meetings with community-based and nongovernmental organizations, government and referral service providers. ▪ Understand activities of self-help groups and community groups.

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>Peer supervisor training</p> <ul style="list-style-type: none"> ▪ On-boarding training for new peer supervisors. <ul style="list-style-type: none"> — Development/adaptation of curricula, including microplanning, programmatic mapping, data entry/consolidation, analysis, interpretation/reporting. — Implementation of trainings. — Refresher trainings and new skills training. ▪ Development/adaptation of existing curricula. <ul style="list-style-type: none"> — Implementation of trainings. 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p>	<p>On-boarding training</p> <p>Estimate two times per year, depending on turnover.</p> <p>Refresher training</p> <p>Every six months.</p>
<p>Peer supervisor materials</p> <ul style="list-style-type: none"> ▪ Data consolidation and display tools. ▪ Materials for supporting peer educators. 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p>	
Peer navigators			
<p>Peer navigator hiring</p> <p>Support key population members in need of medical services at a ratio of roughly 1:20 to 1:30.</p> <ul style="list-style-type: none"> ▪ Salary of peer navigators. ▪ Private room from which peer navigator will work. ▪ Reimbursement for out-of-pocket expenses (e.g., airtime and travel). ▪ Additional costs associated with navigation work, depending on project design (e.g., electronic tablets/data collection phones, bicycles and cases/backpacks to carry forms). ▪ Costs associated with ensuring safety and security of outreach workers (e.g., badges, uniforms, phones and safety plans). 		<p>HIV</p> <p><i>Module:</i> Treatment, care and support</p>	<ul style="list-style-type: none"> ▪ Peer navigators work full-time as part of a case management team, supporting HIV-positive and HIV-negative clients remain adherent to antiretroviral medicines and other medications (including PrEP). ▪ Peer navigators are usually HIV-positive (or HIV-affected), medication-adherent role models who understand—and can communicate clearly and accurately—how to access and use key services. ▪ Ratios are dependent on the complexity of cases, tracing those lost to follow-up and taking on other responsibilities (such as tracking key data from clinics). ▪ They may or may not be key population members, depending on the preference of the key population community. ▪ Duties might include: <ul style="list-style-type: none"> — Referral to clinical, psychosocial and other care and support services. — Accompaniment to appointments (including support with transportation). — Adherence support. — Routine appointment reminders. — Follow-up for missed appointments. — Tracking those lost to follow-up. — Other activities will depend on the specific project.

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>Peer navigator training</p> <ul style="list-style-type: none"> ▪ On-boarding training for new navigators. <ul style="list-style-type: none"> — Development/adaptation of existing curricula, including microplanning and programmatic mapping. — Implementation of trainings. — On-the-job training. ▪ Refresher trainings and new skills training. <ul style="list-style-type: none"> — Development/adaptation of existing curricula. — Implementation of trainings. 		<p>HIV</p> <p><i>Module:</i> Treatment, care and support</p>	<p>Peers educators may be promoted to peer navigators. If this is the case, they should receive additional training to ensure they:</p> <ul style="list-style-type: none"> ▪ Understand the responsibilities and goals of the position: linkage to, support for treatment adherence and long-term retention, and viral load monitoring and adherence for medical prevention. ▪ Understand the imperative of confidentiality and data safety. ▪ Understand treatment and medical prevention thoroughly in order to continue to improve treatment and prevention literacy of their clients and to help manage side-effects. ▪ Have expert knowledge of all the relevant facility- and community-based services available for their beneficiaries. ▪ Understand monitoring forms and basic data dashboards. <p>If peer navigators are new, they should receive much of the training that peer educators receive, plus additional peer navigator training.</p>
<p>Peer navigator materials</p> <ul style="list-style-type: none"> ▪ Data collection and display tools. ▪ Materials for supporting clients, such as educational materials, approaches to support adherence and referral to community support. 		<p>HIV</p> <p><i>Module:</i> Treatment, care and support</p>	
Case managers			
<p>Case manager hiring</p> <ul style="list-style-type: none"> ▪ Salary. ▪ Private room in which they can work. ▪ Reimbursement for out-of-pocket expenses (e.g., airtime or travel). 		<p>HIV</p> <p><i>Module:</i> Treatment, care and support</p>	<ul style="list-style-type: none"> ▪ Case managers generally have received professional training and have significant experience supporting beneficiaries' use of services within a network. ▪ Their responsibility may be the following activities: <ul style="list-style-type: none"> — Service planning. — Service plan implementation. — Coordination. — Clinical guidance. — Monitoring and follow-up. — Case conferencing. — Crisis intervention. — Advocacy for services. — Consultation with providers. — Psychosocial support. — Supportive counselling. — Working with services outside of catchment area. <p>Note: The actual structure of the case management team will depend on country regulations and project financial resources.</p>

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
Case manager training <ul style="list-style-type: none"> Develop training and implement. 		HIV <i>Module:</i> Treatment, care and support	<ul style="list-style-type: none"> Case managers may need to be oriented to issues of key populations and data forms related to the project.
Higher level supervisors and support			
<ul style="list-style-type: none"> Field managers. Programme managers. 		HIV <i>Module:</i> Prevention – key populations AND <i>Module:</i> Treatment, care and support <ul style="list-style-type: none"> The choice depends on the way programme is organized and services being delivered (e.g., prevention or treatment). 	<ul style="list-style-type: none"> The peer supervisors and the peer navigators/case managers will be supervised and supported by additional managers in an organization. Positions will be decided by each programme as they design their organizational chart and reporting/support responsibilities. <ul style="list-style-type: none"> An example of an organizational chart can be found in Annex 3 of: Key population program implementation guide. Washington (DC): FHI 360/LINKAGES; 2017 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-implementation-guide.pdf, accessed 4 May 2020).
Outreach design and refresh			
Programmatic size estimates (PSE) and site mapping <ul style="list-style-type: none"> Costs include: form development, training, interviewer remuneration, travel and technical assistance. Full details on PSE can be found in the Global Fund publication. 	Part 1: Section 1 Part 2: Section 8 and Section 9	RSSH <i>Module:</i> Health management information systems and M&E <i>Intervention:</i> Surveys	<ul style="list-style-type: none"> In order to plan services, new PSE and site mapping for high-risk venues and services needs to be done when services are started for the first time in a city. <ul style="list-style-type: none"> For more information, see: The Global Fund, WHO, UNDP, PEPFAR, University of Manitoba, UNAIDS et al. Using programmatic mapping to improve programme access and coverage for key populations: guidelines for countries. 2016 (https://hivpreventioncoalition.unaids.org/resource/using-programmatic-mapping-to-improve-program-access-and-coverage-for-key-populations-guidelines-for-countries/, accessed 6 August 2020)
Participatory site mapping and validation <ul style="list-style-type: none"> Remuneration and travel support for field work, forms and data analysis. 		RSSH <i>Module:</i> Health management information systems and M&E <i>Intervention:</i> Surveys	<ul style="list-style-type: none"> Several days per site for participatory mapping, and then several hours per high-risk venue for walk-around spot validation. This is often done by existing outreach teams, remunerated peers and supervisors, with support from data managers. Repeat site validation and participatory site mapping updates every six to 12 months.
Online survey and social media mapping <ul style="list-style-type: none"> Costs for implementing a social media mapping exercise include time of a field coordinator and mapping team, and potentially costs to facilitate group discussions with community organizations. From planning through implementation, the activity 		RSSH <i>Module:</i> Health management information systems and M&E <i>Intervention:</i> Surveys	Online planning/mapping activities will determine what percentage of outreach should later be done online.

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>need not take longer than a month, and it may take much less time.</p> <ul style="list-style-type: none"> Online survey costs include the usual cost for tool development/testing, analysis and reporting, plus incentives for participation, cost of survey account and advertising of survey. 			
<p>Annual national meetings</p> <ul style="list-style-type: none"> Meeting chaired by national authority with broad participation (meeting and travel costs). Data analysis and data consolidation for meeting (over and above routine programme monitoring at the national level) (staff time and consultant time). Planning process for staged scale-up design (staff time, consultant time). Programme coordination support for scale-up implementation (staff time). 		<p>RSSH</p> <p><i>Module:</i> Health management information systems and M&E</p> <p><i>Intervention:</i> Analysis, evaluations, reviews and transparency</p>	
Structural interventions/community empowerment			
<p>Addressing safety and security of implementers and beneficiaries</p> <ul style="list-style-type: none"> Develop a comprehensive prevention plan and implement: <ul style="list-style-type: none"> Staff time or consultant to develop plan, phone trees, WhatsApp alert site and security assessments. Training for staff and beneficiaries on safety and security measures. Procurement of security equipment, personnel and software (e.g., closed circuit television, message encryption, guards and electric fencing). Have resources in place to respond immediately for: <ul style="list-style-type: none"> Emergency support (medical care, legal support, safe space and counselling). Provision of emergency funding. Advocacy with stakeholder (staff time). 	Part 1: Section 3	<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p><i>Intervention:</i> Community empowerment OR addressing stigma, discrimination and violence</p>	<p>Checklist for security elements can be found in:</p> <p>Safety and security toolkit: strengthening the implementation of HIV programmes for and with key populations. Durham (NC): FHI 360; 2018 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-safety-security-toolkit.pdf, accessed 4 May 2020).</p> <p>For programmes that meet and connect with key populations through online and mobile platforms, online outreach can carry other risks. Anonymity of individuals cannot be assured when using some common online platforms. The following resources discuss this in greater detail.</p> <ul style="list-style-type: none"> Going online to accelerate the impact of HIV programs. Washington (DC): FHI 360, LINKAGES Project; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vision-going-online.pdf, accessed 4 May 2020). Empowering LGBTQ+ organizations in at-risk areas to protect themselves digitally. In: Safe Queers [Internet]. Safe Queers; c2020 (https://safequeers.org/, accessed 4 May 2020).

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>Safe spaces</p> <ul style="list-style-type: none"> ▪ Rent. ▪ Refurbishment (auditory and visual privacy if used for medical or counselling services). ▪ Recurrent costs (utilities, staffing, security and insurance). ▪ Security cameras. 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p><i>Intervention:</i> Community empowerment</p>	
<p>Self-help groups and community committees</p> <ul style="list-style-type: none"> ▪ Initial support to organize. ▪ Space and clerical supplies. ▪ Seed funding. 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p><i>Intervention:</i> Community empowerment</p>	
<p>Violence prevention and response</p> <ul style="list-style-type: none"> ▪ With legal input, understand laws and regulations related to key populations (consultant). ▪ Develop key population training for legal literacy and rights under the law (curriculum development and training implementation). ▪ Establish rapid response system: <ul style="list-style-type: none"> — Disseminate contact information. — Establish contacts/agreements with medical and legal services that may be needed. 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p><i>Intervention:</i> Addressing stigma, discrimination and violence (if directed towards a specific key population)</p> <p><u>OR</u></p> <p>HIV</p> <p><i>Module:</i> Reducing human rights-related barriers to HIV/TB services</p> <p><i>Intervention:</i> Legal literacy (“Know Your Rights”) (can be used when it refers to key populations in general)</p>	<ul style="list-style-type: none"> ▪ Developing contacts with lawyers for legal advice/representation is also important. Ideally this would be pro bono.
<p>Advocacy with local police and law enforcement</p> <ul style="list-style-type: none"> ▪ With legal input, understand laws and regulations related to key populations (consultant). ▪ Develop curriculum for local police and law enforcement. ▪ Implement training with lawyers as part of training team. 			<ul style="list-style-type: none"> ▪ Establish routine meetings between law enforcement and communities, if feasible.

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>Legal literacy and rights training/paralegal training</p> <ul style="list-style-type: none"> With legal input, understand laws and regulations related to key populations (consultant). Develop curriculum. Implement training with lawyers as part of training team. 			<ul style="list-style-type: none"> Paralegal training is a more intensive training with selected community members to enable them to advise community members on common issues. It is important to have established links with legal aid/lawyers for advice.
<p>Addressing health-care barriers (e.g., provider stigma, clinic service hours and stigma in the setting)</p> <ul style="list-style-type: none"> Consultation with community and providers to understand clinic barriers. Design and implement trainings for providers. Develop fora for routine input by communities on clinical services. 		<p>HIV</p> <p><i>Module:</i> Reducing human rights-related barriers to HIV/TB services</p> <p><i>Intervention:</i> Human rights and medical ethics related to HIV and HIV/TB for health-care providers</p>	
Boosting prevention and treatment cascades			
<p>Staffing of outreach platform</p> <ul style="list-style-type: none"> Peer educators. Peer supervisors. Peer navigators. Case managers. 	Part 1: Section 5 through Section 7	See Outreach Staff and Supervisors budget section above.	
<p>Sufficient prevention commodity supply per estimated need</p> <ul style="list-style-type: none"> Funds to purchase commodities (if not supplied by government). Logistic management personnel at community-based or nongovernmental organization charged with: <ul style="list-style-type: none"> Quantification. Ordering/requisitioning. Monitoring deliveries and stock at drop-in centres and to peer educator staff. Vehicles/fuel to support logistics. Methods for estimating demand (commonly part of client intake or risk assessments). 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p><i>Interventions:</i></p> <p>Condom and lubricant programming, PrEP, harm reduction interventions for drug use (needle-syringe programmes, OST, overdose prevention and management, depending on the type of prevention commodities).</p>	<p>Possible prevention commodities:</p> <ul style="list-style-type: none"> Condoms. Lubricants. Needles and syringes. Self-test kits (if part of country guidelines). <p>Ideally, the type of commodity is informed by the preferences of the key population.</p>

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>If clinical services are provided by the programme</p> <ul style="list-style-type: none"> ▪ Hire clinical staff as needed (e.g., physician, nurses, counsellors, laboratory technician, pharmacist). ▪ Procure necessary clinical equipment and supplies for services offered (e.g., exam lights and exam couch). ▪ Procure/source necessary diagnostics and treatments. Ensure quality control mechanisms (e.g., internal controls and outside laboratory). ▪ Develop necessary clinical recording forms/electronic records and security systems to protect the data (e.g., encryption, passwords, locked cabinets). 		<p>HIV</p> <p><i>Module:</i> Prevention – key populations</p> <p><i>Intervention:</i></p> <p>Sexual and reproductive health services, including STIs</p> <p><u>OR</u></p> <p>HIV</p> <p><i>Module:</i> Differentiated HIV testing services</p> <p><i>Intervention:</i></p> <p>Facility-based testing.</p> <p>Community-based testing. or</p> <p>Self-testing.</p> <p>HIV</p> <p><i>Module:</i> Treatment, care and support</p> <p><i>Interventions:</i></p> <p>Differentiated antiretroviral therapy service delivery and HIV care,</p> <p>treatment monitoring–drug resistance,</p> <p>treatment monitoring–antiretroviral toxicity,</p> <p>treatment monitoring–viral load, or</p> <p>prevention and management of coinfections and comorbidities</p>	<ul style="list-style-type: none"> ▪ Depending on the programme, clinical services offered can include HIV testing and counselling, STI screening and treatment, PrEP, post-exposure prophylaxis (PEP), antiretroviral medicine administration, tuberculosis screening and treatment, and mental health support. ▪ Service provision should meet international standards. See World Health Organization (WHO) guidance and in-country guidance for recommendations. ▪ Diagnostics and treatments often will be provided by the government.
Monitoring and management			
<p>Defined key population monitoring system established</p> <ul style="list-style-type: none"> ▪ Paper formats designed and tested. ▪ Electronic data collection design and tested. ▪ Dashboards for multiple levels designed. ▪ Data quality assurance mechanisms in place. ▪ Data protection mechanisms in place. 	<p>Part 2: Section 10 through Section 12</p>	<p>RSSH</p> <p><i>Module:</i> Health management information systems and M&E</p> <p><i>Intervention:</i> Routine reporting</p>	<p>Indicators should at a minimum be specified for the programme but ideally by government or agreed upon by all implementers with a central reporting mechanism for visibility at high levels and the ability to view performance of individual geographic areas and individual implementing partners.</p>

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>Cadence of project management/supervisory meetings established and supported</p> <ul style="list-style-type: none"> ▪ Travel supported, as needed. ▪ Data consolidation/ dashboard development for discussion (depends on meeting, technical officer’s time or consultant). Includes: <ul style="list-style-type: none"> — Programming indicators (contacts, returns, retention). — Administrative records (such as supply availability). ▪ Depending on the management level, consolidate community monitoring and other inputs from communities for discussion (community member’s time, technical officer’s time or consultant). 		<p><i>Module:</i> Programme management</p> <p><i>Intervention:</i> Grant management</p>	<p>Management/supervisory meetings suggested</p> <ul style="list-style-type: none"> ▪ Individual peer educator/peer supervisor weekly meetings. ▪ Peer educators/peer supervisor monthly meeting. ▪ Peer navigator/case manager weekly meetings discuss individual cases, consider problems, and develop solutions to ensure optimal outcomes for each beneficiary. ▪ Project-level meeting of peer navigators, peer supervisors, peer educators, case manager, community members on a monthly basis to review data, solve problems, invite community insights, share experiences/learnings and determine next steps. ▪ Monthly meeting of peer supervisors and case managers with field supervisors to review data, problem-solve and plan next steps. ▪ Meeting of selected project staff, community, government and referral health facilities occurs monthly to review programme data and community monitoring data, address gaps, conduct shared problem-solving and plan action.
<p>Community-led quality monitoring</p> <ul style="list-style-type: none"> ▪ Routine quality monitoring or qualitative assessments (i.e., focus groups): <ul style="list-style-type: none"> — Support for community to develop data collection forms (consultant). — Training of community monitors on international standards of quality services. — Support for routine data collection. <ul style="list-style-type: none"> o Remuneration of data collectors. o Support for data analysis and reports. o Facilitating access to services being assessed. — Support for analysis, reporting and participation in shared problem-solving meetings and links with key population advocacy groups at the national level. 		<p>RSSH</p> <p><i>Module:</i> Health management information systems and M&E</p> <p><i>Intervention:</i> Programme and data quality</p> <p><u>OR</u></p> <p><i>Module:</i> Community systems strengthening</p> <p><i>Intervention:</i> Community-based monitoring</p>	<p>As noted in Section 11, much of the community input can be obtained by working through peer educators who will have a constant presence in the field. Communities or programmes may want a more systematic assessment of the community perceptions of overall service delivery, the impact of structural barriers or the interventions to address. If so, community groups should be supported and funded to collect data routinely on the programme, the associated referral services and the context of those services to contribute to shared problem-solving locally and to report upward to national key population advocacy groups.</p> <p>Note: Routine monitoring data and quality monitoring will answer the question “Are the geographic footprint, quality of coverage and service uptake adequate (approximately 80% of the population) over time?” If the answer is “no,” then it needs to be understood why not.</p>

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
<p>Monitoring key outcomes (every six to 12 months)</p> <ul style="list-style-type: none"> ▪ Polling booth or other surveys to capture key outcomes. <ul style="list-style-type: none"> — Study design and budgeting (consultant). — Training of study administrators. — Equipment for study. — Conducting study (travel and time). — Data analysis, report writing and reporting back to communities. 		<p>RSSH</p> <p><i>Module:</i> Health management information systems</p> <p><i>Intervention:</i> Surveys</p>	<p>Note: Monitoring key outcomes will give an indication if the programme is increasing the use of HIV prevention interventions, testing and linkage to testing and retention, or if it is impacting structural barriers in the environment for key populations. If it is not, course corrections can be investigated and implemented.</p>
<p>Note: The following two surveys are not necessarily part of the trusted access platform, but they do collect important data to validate the monitoring data described above and to assess the impact of work. They should be implemented across all partners.</p>			
<p>The People Living with HIV Stigma Index 2.0 (Stigma Index 2.0)</p> <ul style="list-style-type: none"> ▪ Ensure that results of the study are made available as soon as possible by having sufficient funds for analysis, ensuring that data cleaning is simultaneous with collection, and not waiting for peer review of the publication to release findings in report form. ▪ Ensure report-back to communities on the findings. 		<p>RSSH</p> <p><i>Module:</i> Health management information systems and M&E</p> <p><i>Intervention:</i> Survey</p>	<ul style="list-style-type: none"> ▪ Recommended frequency for the Stigma Index 2.0 survey is every two to three years. ▪ The estimated cost is US\$ 50 000 to US\$ 150 000. ▪ The process should be led by the national network(s) of people living with HIV, with a broad multistakeholder partnership. ▪ Information and technical support is available from the Global Network of People Living with HIV (plhivstigmaindex@gnpplus.net). ▪ Information is available at: https://www.stigmaindex.org/
<p>Integrated biological and behavioural survey (every three to four years)</p> <ul style="list-style-type: none"> ▪ Ensure that the results of the study are made available as soon as possible by having sufficient funds for analysis, ensuring that data cleaning is simultaneous with collection, and not waiting for peer review of the publication to release findings in report form. ▪ Ensure report-back to communities on the findings. ▪ Use all data—monitoring and integrated biological and behavioural surveys—to assess programme impact and evaluation of the programme. 		<p>RSSH:</p> <p><i>Module:</i> Health management information systems and M&E</p> <p><i>Intervention:</i> Survey</p>	<p>Full details of study design and budget requirements can be found in: WHO, CDC, UNAIDS, FHI360. Biobehavioral survey guidelines: for populations at risk for HIV. Geneva: WHO; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf;jsessionid=82A3B66F260B-D39806A47DC4CB82956F?sequence=1, accessed 4 May 2020).</p>

Budget category/item	Platform areas supported	Global Fund modular framework location	Notes
Community capacity-building			
<ul style="list-style-type: none"> ▪ Capacity-building needs assessment/planning process. ▪ Technical capacity unit or similar capacity-building mechanism. ▪ Community systems strengthening plan/ activities. ▪ Organizational and institutional capacity-strengthening plan/ activities. ▪ Adaptation of existing capacity-building materials or development of new ones. ▪ Support for establishment of self-help groups/ community committees. ▪ Support for communities to engage fora, processes and decision-making bodies at the local, regional and national levels. ▪ Support for communities to link to national key populations advocacy groups. 	Part 2: Section 13	<p>RSSH</p> <p><i>Module:</i> Community systems strengthening</p> <p><i>Intervention:</i> Institutional capacity-building, planning and leadership development</p>	<ul style="list-style-type: none"> ▪ There is a significant amount of community capacity-building in the training of the cadres of outreach workers and community in addressing structural interventions. ▪ The capacity-building described here also refers to strengthening organizational and institutional capacity, such as: <ul style="list-style-type: none"> — Governance. — Financial management. — Internal policies. — Leadership development. — Programme management. — Monitoring and evaluation, learning and reporting. — Sustainability planning and resource mobilization. — Partnerships and community organizing and advocacy.

Table 3. Additional budget considerations for online platforms

Issue	Considerations
<p>Potential risks of online services to key population communities</p>	<p>Ensuring safe and confidential online access</p> <ul style="list-style-type: none"> ▪ While many key populations prefer to meet and connect through online and mobile platforms to avoid confrontation and disclosure risk in physical venues, online outreach can carry other risks: <ul style="list-style-type: none"> — Anonymity of individuals cannot be assured when using some common online platforms. — Online platforms collect and use data and have information on phone numbers and IP addresses that may lead to data security vulnerabilities. — In some instances, key populations are pursued by the law through state and nonstate actors who actively seek to identify key populations online and use their online engagement against them. ▪ Programmes need individuals who are knowledgeable in these technologies to advise on possible risks and ways to mitigate them (alongside community input). It is imperative to ensure safe and confidential access to online platforms.
<p>Understanding local online environment and opportunities</p>	<p>Understanding what online approaches are preferred</p> <ul style="list-style-type: none"> ▪ As in traditional outreach, planning for online outreach and service information means understanding which online approaches are preferred in the setting and what HIV service options are needed in order to design programmes to meet the needs of the key population members in a manner they find most appealing and appropriate. ▪ Some approaches that can be used are: <ul style="list-style-type: none"> — Social listening approaches (a technique used by online marketing to understand the perceptions about brands). — Online surveys. — Focus groups. — Community advisory committees. <p>Mapping online opportunities for access</p> <ul style="list-style-type: none"> ▪ Programmes also need to map online places for future outreach. Approaches to mapping include social media mapping (identifying online personalities or specific sites that are popular among the focus population). ▪ Collaboration with dating apps is an additional option.
<p>Developing and implementing an online presence</p>	<p>Defining programme objectives and target populations</p> <ul style="list-style-type: none"> ▪ The programme should decide on its objectives of going online (information/education, HIV prevention approaches, HIV testing, linking HIV-positive people to medical and support services). This decision will significantly impact the programming budget. ▪ If the use of the online platform is to advertise/develop interest in current existing services (e.g., to provide some services virtually or to reach key population individuals in a similar subgroup as the current programme), then the costs would not be great. ▪ However, the intent may be to reach a much broader swathe of key population members, including those: <ul style="list-style-type: none"> — Who do not want to disclose their activities. — Who want quick, anonymous access to HIV services, but not necessarily through key population providers. — Who fear disclosure among their community or because of other differences. ▪ In those instances, the programme may entail some new approaches to reach them (such as influencers) and link them to HIV services (like online booking, links to private providers, or engaging mail services to deliver in-home services like self-test kits or medication with prescription).

Issue	Considerations
	<p>Determine human and financial resource needs</p> <ul style="list-style-type: none"> ▪ Assess the human and financial resources for going online, including: <ul style="list-style-type: none"> — Outside creative content developer. — Staff capable of working online. — Infrastructure/device procurement. — Monitoring. — Management. — Ensuring online referrals are acceptable/accessible. — Government approvals. — Security and consent protocols. <p>Methods for outreach</p> <ul style="list-style-type: none"> ▪ Determine what methods will be used for outreach (e.g., social network outreach, social influencer outreach or social profile outreach), and where and how the peers, peer supervisors, peer navigators and case managers work in this setting. <p>Mechanisms of referral</p> <ul style="list-style-type: none"> ▪ If the intent is to refer to providers, what are the mechanisms for referral and appointments, and will there be any offline interaction requiring additional staff time and safe locations?
Providing ongoing support	<p>Structure for ongoing support</p> <ul style="list-style-type: none"> ▪ Similar to the work of peer educators and peer navigators, the peer educator builds relationships online. ▪ This requires mechanisms for convenient and private follow-up and re-engagement, as well as peers skilled in using the technology. ▪ Online and engagement approaches might include virtual education and support, virtual reminders, and support for peer or partner referrals.
Looking at data and continued improvement	<p>Monitoring activities</p> <ul style="list-style-type: none"> ▪ Online activities make real-time monitoring feasible. ▪ Data can be looked at daily and used to refine approaches. ▪ Monitoring systems can be established. ▪ For example, modified clinic intake forms can be used to record client arrivals from online outreach or the use of the online reservation app, which allows for online referrals, clinic reporting, complete cascade tracking and case management. Staff managing the online work can also monitoring real-time indicators such as clicks, chats, referrals, HIV testing and linkage to treatment. ▪ Programmes can get electronic feedback on services. Some programmes use crowdsourcing to get ideas for improvement.

Source: Going online to accelerate the impact of HIV programs. Washington (DC): FHI 360, LINKAGES Project; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vision-going-online.pdf>, accessed 4 May 2020); Online reservation app for HIV service delivery programs. FHI 360; 2019 (<https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-ora-technical-brief.pdf>, accessed 4 May 2020).

Annex B. Examples of different stages in implementing a trusted service platform

Table 4. Maturity model for a trusted service platform

	Poor practice	Start-up	Consolidating	High quality
Planning/re-planning	<ul style="list-style-type: none"> ▪ Random visits to hotspots by mobile teams chasing one-off targets. ▪ No continuous high-risk venue presence or community engagement. ▪ Peer educators unsupervised. ▪ No remapping to update population size estimates (PSE) and locations. 	<ul style="list-style-type: none"> ▪ High-level mapping to identify national priority areas and programme gaps. ▪ Programmatic mapping and PSE to guide local outreach/service referral. ▪ Peer outreach designed for continuous hotspot presence. 	<ul style="list-style-type: none"> ▪ Microplanning to empower community outreach workers to assess and improve work. ▪ Targets with regular dashboard review of priority programme indicators (PPIs), HIV testing and counselling, and linkage to care to assess progress. ▪ Periodic high-risk venue validation to refine PSE denominators and targets, and to look for individuals not covered. 	<ul style="list-style-type: none"> ▪ Scale achieved through coverage of main national sex work areas. ▪ Outreach uptake >90% PSE at the majority of sites. ▪ Outreach frequency at least monthly. ▪ Regular HIV testing and counselling of HIV-negative individuals per standard operating procedures of the country. ▪ High linkage to care and adherence. ▪ Special efforts to find the unserved.
Target-setting	<ul style="list-style-type: none"> ▪ Narrow reach, testing and yield targets. ▪ Lack of unique identifiers does not permit relating performance to PSE. 	<ul style="list-style-type: none"> ▪ Clear targets set for at least four PPIs for outreach: outreach uptake and frequency, clinic uptake and frequency. ▪ Clear targets for linkage to treatment and retention. 	<ul style="list-style-type: none"> ▪ Documented progress towards >90% outreach uptake, frequent outreach contacts, >80% clinic uptake and regular check-ups. ▪ Documented progress on linkage to treatment and retention. 	<ul style="list-style-type: none"> ▪ Outreach targets stratified by risk, with more frequent contacts (weekly) for those assessed to be at highest risk. ▪ Approaches developed for differentiated approaches to linkage to treatment and retention.
Monitoring/supervision	<ul style="list-style-type: none"> ▪ No monitoring/supervision of progress (outreach uptake/frequency). ▪ No population denominators. 	<ul style="list-style-type: none"> ▪ Monitoring and supervision framework in place to track progress and support outreach and clinic staff. 	<ul style="list-style-type: none"> ▪ Microplanning systems with weekly supervision and planning of outreach work, focus on PPIs. ▪ Peer navigator plan the follow-up of key population members. 	<ul style="list-style-type: none"> ▪ Monthly and quarterly meetings at higher levels to review data, solve persistent problems and support local teams.
Outreach	<ul style="list-style-type: none"> ▪ Uptake and frequency not monitored. 	<ul style="list-style-type: none"> ▪ Peer outreach organized to cover high-risk venues with appropriate ratios (approximately 1:50 peer educators to key populations). ▪ Peer navigators organized to support key population members with treatment or medical prevention (a ratio of 1:20 to 1:30 of peer navigators to key population members needing services). 	<ul style="list-style-type: none"> ▪ Approaching 90% outreach uptake and monthly outreach contacts. 	<ul style="list-style-type: none"> ▪ High level of coverage (90% or “saturation”) coverage, full uptake with frequent contact.

	Poor practice	Start-up	Consolidating	High quality
Prevention commodity interventions (condoms/lubricants, needles and syringes)	<ul style="list-style-type: none"> ▪ Intermittent, no planning, systems or targets based on need, intermittent supply with stock-outs. 	<ul style="list-style-type: none"> ▪ Regular condom/lubricant (and needle and syringe) distribution through outreach, supported by functioning logistics, with messages reinforced at clinic visits. 	<ul style="list-style-type: none"> ▪ Condom promotion and distribution reflects assessed need (i.e., it is in relation to the number of reported clients). 	<ul style="list-style-type: none"> ▪ Strong condom promotion and distribution system, with no stock-outs or interruptions. ▪ Condom use assessed by polling booth or related survey method.
Clinical/medical services	<ul style="list-style-type: none"> ▪ Uptake and frequency not monitored. ▪ No assistance or follow-up to referrals. 	<ul style="list-style-type: none"> ▪ Promotion of clinic visits for regular check-ups. ▪ Referral system for additional medical services established. 	<ul style="list-style-type: none"> ▪ >80% clinic uptake, followed by regular check-ups. ▪ Referred individuals assisted with making it to clinics and efforts made to support adherence. 	<ul style="list-style-type: none"> ▪ Regular quarterly check-ups. ▪ Evidence of STI declines. ▪ Robust case management in place with documented high adherence to medical treatment and prevention.
Structural interventions	<ul style="list-style-type: none"> ▪ No attention. 	<ul style="list-style-type: none"> ▪ Assessment and dialogue about main problems. 	<ul style="list-style-type: none"> ▪ Violence reporting and response mechanism. ▪ Linkages established with national key population networks. 	<ul style="list-style-type: none"> ▪ Self-help groups/community committees set priorities, implement responses and monitor impact.
Community ownership	<ul style="list-style-type: none"> ▪ No attention. 	<ul style="list-style-type: none"> ▪ Assessment and initial engagement of programme with key population community. 	<ul style="list-style-type: none"> ▪ Programme working with key population community in implementation of interventions. Community has role in decision-making. 	<ul style="list-style-type: none"> ▪ Key population community members capacitated with increasing leadership roles in the nongovernmental and community-based organizations, and a clear progression plan for increasing community responsibility and leadership.

Annex C. Outreach and case management team composition and roles

Table 5. Outreach and case management team composition and roles

Peer educators/outreach workers	Peer navigators
<p>Peer educators/outreach workers function as part of the case management team through:</p> <ul style="list-style-type: none"> ▪ Reaching key populations. ▪ Ensuring they are engaged in prevention and clinical services, and that they are re-engaged in services if needed. ▪ Assisting the team in tracking individuals who may be inactive/lost to follow-up. <p>Depending on the programme, peer educators and workers can often become peer navigators or peer supervisors with the appropriate training and experience.</p>	<p>Peer navigation is an approach used by programmes across countries to ensure that key populations are linked to and guided through the process of accessing (and remaining in) needed services and participate in the clinical case management team (with case manager and possibly clinical staff).</p> <p>Peer navigators are usually HIV-positive (or HIV-affected), medication-adherent role models who understand how to access and use key services, and who can communicate that information clearly and accurately.</p> <p>The goal for peer navigation is that newly diagnosed individuals are supported:</p> <ul style="list-style-type: none"> ▪ To enroll in treatment and remain within the service network in order to achieve viral suppression. ▪ To enroll in medically based prevention (e.g., antiretroviral therapy) within the service network. ▪ To remain adherent. <p>Peer navigation picks up where peer outreach traditionally leaves off. Peer navigators work full-time as part of a case management team to assist HIV-positive service beneficiaries with enrolling in and accessing care and treatment services. They support them to identify and overcome barriers that interfere with achieving personal health-related goals. They also assist HIV-negative service beneficiaries to obtain medically based prevention and support them.</p> <p>Peer navigators can be drawn from the pool of peer outreach workers, but they should receive additional training to ensure they have expert knowledge about all of the relevant facility- and community-based services available for their beneficiaries. The potential should also exist for them to be trained to provide case management services and understand their responsibility in maintaining confidentiality.</p>
Peer supervisors	Case manager
<p>Peer supervisors strengthen outreach efforts by supporting and overseeing peer educators in their work to reach key populations and keep them engaged in prevention and clinical services.</p> <p>They work closely with peer educators in reviewing their work and data, helping them plan the subsequent work and engaging in shared problem-solving. Their role is also to consolidate outreach data from the peer educators and ensure it is reported upwards, and they participate in relevant management and data review meetings.</p>	<p>Case managers strengthen patient outcomes throughout the HIV prevention and care continuum, including:</p> <ul style="list-style-type: none"> ▪ Linkage to antiretroviral therapy-based prevention. ▪ Early linkage to care and treatment. ▪ Retention in care and treatment. ▪ Sustained antiretroviral therapy adherence through assessing client needs. ▪ Development, monitoring and evaluation of treatment plans and progress. ▪ Liaison between the client and other service providers to ensure comprehensive client care. <p>Depending on the setting (community- or facility-based), the case manager's role might vary. Various cadres (including peer navigators) can provide case management services and be designated as a case manager, depending on the context and programme. A case manager can also play a role in coordinating with facilities and personnel that are not in the catchment area to ensure that key populations are being supported and linked to appropriate services.</p>

Annex D: Summary of World Health Organization recommendations concerning key populations

Table 6. World Health Organization comprehensive package of interventions for key populations

Health sector interventions	
HIV prevention	
1.	The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).
2.	Oral pre-exposure prophylaxis (PrEP) containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for key populations at substantial risk of HIV infection as part of combination HIV prevention approaches.
3.	Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
4.	Voluntary medical male circumcision (VMMC) is recommended as an additional important strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic and generalized HIV epidemics and low prevalence of male circumcision.
Harm reduction	
5.	All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes.
6.	All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy in keeping with WHO guidance.
7.	All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice.
8.	People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.
HIV testing and counselling	
9.	Voluntary HIV testing and counselling should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.
HIV treatment and care	
10.	Key populations living with HIV should have the same access to antiretroviral therapy (ART) and to ART management as other populations.
11.	All pregnant women from key populations should have the same access to services for prevention of mother-to child transmission of HIV (PMTCT) and follow the same recommendations as women in other populations.
Prevention and management of coinfections and co-morbidities	
12.	Key populations should have the same access to tuberculosis prevention, screening and treatment services as other populations at risk of or living with HIV.
13.	Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.
14.	Routine screening and management of mental health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from co-counselling for HIV and depression to appropriate medical therapies.
Sexual and reproductive health	
15.	Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.
16.	People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options.

Health sector interventions

17. Abortion laws and services should protect the health and human rights of all women, including those from key populations.
18. It is important to offer cervical cancer screening to all women from key populations, as indicated in the WHO 2013 cervical cancer screening guidelines.
19. It is important that all women from key populations have the same support and access to services related to conception and pregnancy care, as indicated by WHO guidelines, as women from other populations.

Critical enablers

1. Laws, policies and practices should be reviewed and revised where necessary, and countries should work towards decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and non-conforming gender identity and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.
2. Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.
3. Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
4. Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations.
5. Violence against people from key populations should be prevented and addressed in partnership with key population led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

Source: HIV prevention, diagnosis, treatment and care for key populations: consolidated guidelines. Geneva: WHO; 2016 (<https://apps.who.int/iris/bitstream/handle/10665/258967/WHO-HIV-2017.05-eng.pdf>, accessed 4 May 2020).

