

THE LINK

News about HIV Prevention, Care,
and Treatment for Key Populations

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NO WEAK LINKS: STRENGTHENING CAPACITY OF KEY POPULATION PROGRAMS AT EVERY LEVEL

Despite the gains in HIV prevention, care, and treatment for key populations (KPs), many implementing organizations and health care facilities still have limited experience working with KPs, and worse, some stigmatize and discriminate against them (even when that is not their intention). KP-led organizations—while brimming with empathy, passion, and talent—sometimes lack the organizational and technical capacity to implement and scale up programs themselves. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) considers capacity building (or capacity strengthening) an essential component of efforts to reach ambitious HIV treatment targets, and the process is perhaps even more critical for ending the epidemic among populations who carry a disproportionate burden of the infection but have been long underserved by HIV-related programs.

PEPFAR defines capacity building as an “evidence-driven process of strengthening the abilities of individuals, organizations, and systems to perform core functions sustainably, and to continue to improve and develop over time.”¹ Capacity building

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Capacity building at all levels is a critical component of improving and scaling up HIV prevention, care, and treatment programs for key populations.

features strongly in LINKAGES' mission: to *accelerate the ability* of governments, organizations, and private-sector providers to plan and implement services that reduce HIV transmission among KPs. The phrase “accelerating the ability” may sound policy-wonkish, but it implies an important distinction between “doing for” and “helping to do”: the former is only a short-term solution, whereas the latter leads to sustainable programs and a sense of ownership by those who implement them.

This issue of *The LINK* focuses on just a few examples of capacity-building

activities—carried out by, with, and for governments, community-based organizations, health care providers, and members of KPs themselves—to improve the success and efficiency of programs and services for KPs.

For example, on page 7, authors describe how LINKAGES undertook an “acceleration initiative,” led by the University of Manitoba, to build the capacity of its country office staff and in-country partners in 15 countries to deliver high-quality KP programs at scale. To address gaps

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identified, acceleration teams provide technical assistance through in-country mentoring visits and learning sites, among other methods. Topics for technical assistance are wide-ranging, including monitoring and evaluation, peer outreach, and clinical services for KPs.

Clinical and community health care providers are also important recipients of capacity building. The article on page 3 describes the Afya Academy, developed by South Africa-based Anova

cry, “nothing about us without us,” project staff partnered with local KP groups on the analysis, from its design to dissemination of results. KP members were hired as research assistants and trained on qualitative data collection. Research assistants later reported leveraging these skills to work on other studies, present at international conferences, and more. The article on page 5 reveals some additional unanticipated benefits of the project’s unique capacity-building process.

These and many other efforts by those invested in the health and well-being of KPs—and in meeting the broader UNAIDS 90-90-90 goals—are instrumental in creating strong, sustainable programs and organizations that truly meet the needs of the populations they intend to serve.

1. PEPFAR Capacity building and strengthening framework, FY2012. Version 2.0.

Capacity building features strongly in LINKAGES’ mission: to accelerate the ability of governments, organizations, and private-sector providers to plan and implement services that reduce HIV transmission among KPs. The phrase “accelerating the ability” may sound policy-wonkish, but it implies an important distinction between “doing for” and “helping to do”: the former is only a short-term solution, whereas the latter leads to sustainable programs and a sense of ownership by those who implement them.

Health Institute and the International HIV/AIDS Alliance. The Academy is a series of training events for health care providers in Africa to offer stigma-free, KP-competent services in a social and legal environment that is hostile toward the very people they are trying to help. The story on page 9 describes a guide and subsequent trainings developed and facilitated by LINKAGES partner IntraHealth International. These trainings aim to increase health care workers’ empathy for KPs, clinical knowledge, and interpersonal skills in order to help them provide stigma-free, clinically sound, and high-quality comprehensive services.

Building the capacity of KP members themselves empowers them as leaders in their communities and in the HIV response. In Kenya, LINKAGES conducted an analysis of the extent to which gender norms and inequalities affect KPs’ HIV risk and uptake of services. Taking to heart the KP rallying

KP-led efforts—both to serve their communities and build leadership skills among their peers—are also an important part of the capacity-building spectrum. Learn how people who previously injected drugs in Indonesia are supporting others with their addiction and recovery on page 6.

Local implementing partners do the lion’s share of the critical hands-on work in KP communities, and LINKAGES’ partner Pact is building their organizational capacity in program management, financial management, and resource mobilization. On page 11, the author and interviewees discuss capacity-building efforts under way with the Centre for the Development of People (CEDEP) in Malawi. CEDEP’s executive director explains how the organization has made significant strides in areas such as finance, program delivery, human resources, and most significantly, monitoring and evaluation.

AFYA ACADEMY SPEARHEADS MOVEMENT TO DELIVER COMPETENT HEALTH CARE TO AFRICAN KEY POPULATIONS

An informal discussion over a glass of wine led to the first program of its kind: the Afya Academy, a training initiative for clinicians and community workers who provide health care to key populations in Africa.

Pervasive stigma and discrimination against KP members, particularly in Africa, has caused many to avoid seeking assistance and health care when they've needed it. No one wants to visit health facilities where they may be harshly judged, shamed, or made to feel unworthy. In addition, punitive policies and laws that criminalize KPs contribute to their increased vulnerability and a disproportionate burden of HIV infection among them.

So it's no surprise that recognizing and addressing clients' fears of being stigmatized or discriminated against is one of the greatest challenges facing those who provide health services to KP groups in Africa. This challenge

becomes especially daunting when providers have not been trained in providing high-quality, KP-competent services; when they work in a social and legal environment that is hostile toward the very people they are trying to help; and when providers' own values reflect those of the broader society.

One evening at International Conference on AIDS and STIs in Africa (ICASA) 2013, colleagues from Anova Health Institute (Anova) and the International HIV/AIDS Alliance (Alliance) reflected on the fact that while there were increasing numbers of clinicians and community activists working with KPs, very few of them had received formal clinical training to meet their clients' needs. Thus, the idea for the Afya Academy was born: the Academy would not be a physical location but rather a series of training events on KP health care that would be delivered across Africa. The Academy's founders reasoned that if clinicians

and staff from community-based organizations became empowered to provide stigma-free, KP-specific services, then more members of KPs would access and stay connected to HIV and health services and their health outcomes would improve.

"The Afya Academy builds on our ongoing partnership with Anova [through the Sexual Health and Rights Program], which has successfully delivered intensive MSM [men who have sex with men] health care training to clinicians and communities to support them to sharpen their focus, increase their reach, and augment their approaches to service delivery to improve health outcomes and the dignity of African key populations in all their diversity," said Gavin Reid from the Alliance, and a member of the LINKAGES Advisory Board.

An evaluation of these trainings showed that not only did scores on "total knowledge" (a combination of basic psychosocial and more advanced biomedical knowledge) increase from 64 percent to 88 percent among the trainees, but also that homophobic stigma among the cohort decreased by a third.

The first formal Afya Academy was held in December 2016 in Johannesburg. More than 120 people applied, and 26 were selected to participate: nine in the clinical track and 17 in the community track. The participants were from Mozambique, South Africa, Tanzania, Uganda, and Zimbabwe. The Academy included sessions in community and clinical tracks on such topics as diversity; barriers to MSM health; biomedical training with an emphasis on MSM health; fast tracking and implementing the 90-90-90 strategy for all KPs; combination prevention with a focus on pre-exposure prophylaxis for MSM; creative approaches for engaging MSM; HIV care cascade for key populations; pioneering HIV testing services for MSM; safety and security in delivering HIV health services; and



Photo Credit: © Warren Dawson

Farisai Gamariel, Médecins Sans Frontières (MSF), Mozambique, was among the attendees at the first Afya Academy.

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maintaining the physical, sexual, and emotional health and well-being of health care providers.

“The training is vital for me to unpack and appreciate concepts I had heard of but didn’t understand that I will use to advocate, educate, and implement health programmes in rural Uganda.”

– a community-based organization (CBO) participant of the Afya Academy

Glenn de Swardt from Anova emphasized that the Academy is the culmination of three years of research and planning. “We are exceptionally proud that the Academy—the first of its kind on the continent—has been

launched and that we have conducted the first training event,” de Swardt said. “This represents a significant development in how we share expertise, latest innovations, and best practice regarding the complexities of key populations and their sexual and social health. We look forward to developing the Afya Academy to become a major contributor to addressing HIV and sexual and reproductive health, and extending services to marginalized populations across Africa.”

The Afya Academy encourages several participants from the same facility to attend trainings, to help ensure that there is a critical mass for effecting change when they return to work. This tactic has resulted in specific waiting rooms being set aside for MSM and prescriptions being written for lubricants to support the safety of clients carrying this commodity in a specific context. “Going forward we do intend to have a six-month follow up to demonstrate changes and impact on service delivery as an actual requirement of future Academies in order for participants to graduate,” Reid said.

“I learned so much about key populations and why they need our special attention.”

– a clinician who participated in the Afya Academy

The Academy is supported by a website, afya4men.info, that provides nuanced information to MSM in Swahili, French, and English. The site is set to undergo extensive revision and expansion in 2017.

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“NOTHING ABOUT US WITHOUT US”: PLACING COMMUNITY EMPOWERMENT AND LEADERSHIP AT THE CENTER OF A GENDER ANALYSIS

Harmful gender norms and inequalities increase violence and HIV risk while limiting uptake of HIV services among KPs. Identifying and working to transform the gender norms most harmful to KPs can strengthen HIV programs. LINKAGES, together with KP communities, conducted a gender analysis in Kenya to examine how gender norms and inequalities affect KPs' HIV risk and service uptake across the HIV prevention, care, and treatment cascade. One of our explicit goals was to draw on and build the capacity of KP members to conduct a gender analysis.

From design to dissemination, KP members informed the gender analysis through their leadership in a gender analysis task force. In the beginning, the task force helped to recruit, interview, and select research assistants (RAs)

representing four KP groups: gay men and other MSM, sex workers of all genders (SWs), transgender people, and people who inject drugs (PWID). We worked closely with the task force and the FHI 360 Human Resources (HR) department to develop RA qualifications that placed more weight on experience working with KPs and less on degrees obtained, as the task force noted that KP members often have fewer formal educational opportunities due to stigma and discrimination. The HR team and country director also reinforced existing KP-friendly policies and practices. For example, that security staff did not question candidates whose government ID did not match their gender identity and, once hired, RAs received ID cards that reflected their chosen name and official role on the gender analysis team.

Ten RAs participated in a week-long training that covered basic information about all four KPs, gender norms and inequalities as barriers to HIV prevention and treatment, and qualitative data collection. As the study was implemented, RAs worked in KP-specific teams in which they received continuous feedback and support from the principal investigator, local study coordinator, and each other. For example, the study coordinator reviewed interview audio files and field notes and provided feedback to RAs on how to build rapport, ask probing questions, and take detailed field notes.

During the course of the gender analysis, the RAs pilot tested and revised the interview guides to ensure that we asked the right questions, successfully recruited a wide variety of key informants, conducted candid key informant interviews, and packaged and presented the findings from the gender analysis to key stakeholders including members of government.

Because the study had a specific capacity-building goal, we charted each RA's progress over time. The study coordinator observed the gains that each RA made, including increased confidence in conducting interviews and increased understanding of the intersection of gender and HIV. Additionally, in interviews and surveys after completion of the gender analysis, RAs reported that their participation in the gender analysis enhanced their skills in qualitative research and public speaking. Further, RAs reported leveraging these skills to work on other studies, facilitate research trainings, present at international conferences, obtain fellowships, and write evidence-based proposals. To learn more about the RAs and their efforts, read the [LINKAGES KP heroes blog](#).



Photo Credit: © FHI 360

Gender analysis research assistants celebrate graduation from data collection training.

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The capacity-building process, simply by bringing together members of each KP group and providing space for mutual teaching and learning, was also able to help build a shared understanding and to strengthen networks. For example, the transgender RA team expressed that they greatly appreciated the opportunity to teach other KP members what it means to be transgender. All the RA teams noted a better understanding of other KPs and a desire to collaborate more closely after participating in the gender analysis. Further, RAs across KPs connected with each other as the study was implemented.

They provided social support to one another both during the process of conducting the gender analysis—by forming a WhatsApp group to exchange experiences and challenges from their interviews—and beyond. For example, RAs representing SWs, MSM, and PWID provided important information to the transgender RAs on how to collaborate effectively with the National AIDS and STI Control Programme (NAS COP) and its KP programs.

Finally, the gender analysis process, findings, and impacts benefited

enormously from investments in capacity building. As is rightly illustrated in the KP rallying call “nothing about us without us,” it is not possible to conduct quality research on issues affecting KPs without KP members leading the way. The expertise and creativity of the RAs were key to getting relevant, accurate information from a wide variety of sources and then advocating effectively for the use of the gender analysis results (found in the [Nexus of Gender and HIV in Kenya](#) series) in programs and policy. Since completion of the gender analysis, NAS COP has begun to implement a training for health care workers on addressing gender-based violence against KPs and is in conversations with transgender-led organizations on expanding KP programming to include transgender people. And all of these efforts continue to be supported by the same RAs who collected gender analysis data and presented the original findings.

MY SAFE CIRCLE: SURVIVORS WHO INITIATE CHANGE FROM WITHIN

In Jakarta, graduates of two drug addiction recovery programs formed My Safe Circle (MSC) to serve as a peer support group for those who are still struggling with drug abuse. Approximately 36,000 Indonesians inject drugs, and 40 percent of them are living with HIV. Although legislation enacted in 2011 supports harm reduction, including a shift from imprisonment to rehabilitation, many rehabilitation centers have inadequate facilities, are understaffed, and employ dubious and untested treatments. In June 2016, President Joko “Jokowi” Widodo declared a “war on drugs,” and human rights groups feared that it could emulate the brutal crackdown in the Philippines.^{1,2}

MSC was initiated by Steve John Christoph Sundah, who formerly injected drugs, whose energy, optimism, and ties to the community helped him to motivate current and former PWID to participate. Sundah adapted the Narcotics Anonymous (NA) model for the Indonesian context—members do not strictly follow NA’s 12-step approach. For example, NA prohibits anyone who is still using drugs to join, but MSC does allow them to participate. Sundah explained that, “by joining this group, someone who is still using drugs will be supported in an environment that is conducive to change.”

Originally only focused on addiction treatment and outreach services, the group’s mission has evolved to include providing adolescents and young adults with education and services on drug abuse prevention and helping youth and adults in recovery to access HIV prevention, testing, care, and treatment services.

As recovering people who inject drugs become healthy and drug-free, they are encouraged to also begin providing community service and are mentored by more experienced peers. In addition to building their knowledge about recovery, HIV, and other PWID-specific health issues, the new MSC members are also trained in communication, counseling, and leadership skills.

1. Jarkata Post, <http://www.thejakartapost.com/longform/2016/08/31/ill-equipped-rehab-centers-left-staggering.html>.

2. UNAIDS. Do no harm: health, human rights, and people who use drugs. Geneva (Switzerland): UNAIDS; 2016.



To see a step-by-step breakdown of the process and read more about conducting a gender analysis with key populations—with an emphasis on community engagement and capacity building—check out our new [Gender Analysis Toolkit](#).

By: *Giuliana Morales and Alice Olawo, LINKAGES, FHI 360*

STANDARDS, SPEED, AND SCALE: BUILDING CAPACITY TO ACCELERATE SCALE-UP IN KEY POPULATION PROGRAMMING

Scale-up (noun): “the process of doing something in a big way to improve some aspect of a population’s health.”¹

Scale-up is a snappy phrase for a complicated process. Successful programs don’t simply catch on and spread widely because they work and because people need them. Scaling up requires planned, purposeful action with a focus on developing the capacity of local partners to implement at scale. LINKAGES undertook such an endeavor when it launched an acceleration initiative in late 2015, with University of Manitoba (UOM) as a key partner. The goals of the initiative are to hasten and strengthen delivery of a comprehensive package of health services to KPs “at scale”—or, in a big way. Unlike a car’s acceleration, which connotes only speed, LINKAGES’ acceleration efforts simultaneously deliver standards, speed, and scale.

Standards: An important component of LINKAGES’ acceleration is a set of common core standards for KP programming that can be applied globally and adapted locally. These standards are laid out in LINKAGES’ *Key Population Program Implementation Guide* (the acceleration guide), developed with UOM. The document is a practical, user-friendly tool based on global guidance with step-by-step guidance for implementing seven elements of KP programming: population size estimation and mapping, engagement and empowerment of key populations, structural interventions, peer outreach, clinical services, program management, and monitoring and data use. The guide serves as a basis for the project’s technical assistance (TA) to its country staff and implementing partners, and it contributes to the goal that all sites be equally technically competent and their work strategically aligned.

Speed: To help speed the work of scaling up, LINKAGES established “program acceleration teams,”



Photo Credit: Parinita Bhattacharjee

Conducting a microplanning session with peer outreach workers at the Family Planning Association of Malawi (FPAM) drop-in center, Muzuzu, Malawi.

tasked with providing intensive, consistent, and targeted TA to LINKAGES’ country-level programs. These multidisciplinary teams are composed of three to four technical experts in epidemiology, community interventions (including peer outreach and community mobilization), clinical services, programmatic mapping and size estimation, and monitoring. In regional acceleration workshops led by LINKAGES and UOM technical experts, LINKAGES country teams developed concrete action plans for carrying out acceleration, and TA was then designed around helping countries put their plans into action.

Scale: UOM is providing technical support in a growing number of countries, starting with six originally—Kenya, Malawi, South Sudan, Democratic Republic of Congo, Cote d’Ivoire, and Haiti—and expanding to include varying levels of support to Burundi, Barbados, Jamaica, Trinidad and Tobago, and Suriname. So far, acceleration teams have made 122 TA visits (112 of them by UOM) to 15 countries. Within countries, LINKAGES staff are working through their acceleration plans to scale up their reach.

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UOM'S BEST PRACTICES FOR TA

- Design TA in consultation with the end users of the support. This seems obvious, but it isn't uncommon for training to be developed in a vacuum.
- Be flexible and innovative. For example, because of political unrest, it was impossible to provide in-country support in South Sudan or the Democratic Republic of the Congo. Instead, TA workshops for those teams were organized in safer countries nearby.
- Build in time at the end of a TA workshop or mentoring visit to debrief and develop an action plan. This step helps to ensure that participants actually implement the knowledge they gained.
- Stay in regular contact with those who received the TA and offer continuing assistance as needed. Respond to any questions quickly so people don't lose confidence in the TA providers or process.
- Select the TA team carefully, because TA is only as good as the providers. Knowledge and skills are important, of course, but they aren't the only selection criteria. TA providers must have a positive attitude and the ability to work well in teams. The teams should share a sense of responsibility for the success or failure of the country programs receiving TA but also allow the programs to implement what they've learned in whatever manner best suits them.

TA Delivery Models

The means of building capacity to deliver high-quality KP programs at scale vary according to the needs of the countries and organizations that provide them. Some examples include:

In-country mentoring. Acceleration teams visit LINKAGES countries and mentor both implementing partners and the project's country office staff (particularly for newly opened country offices). During a recent weeklong visit to Malawi, for example, UOM met with implementing partners in Lilongwe and Mzuzu and focused on understanding why the number of clinic visits by FSWs and MSM were lower than expected, given the size of the populations. Together, the TA staff and implementing agencies developed strategies with peer outreach workers to improve access to clinics for these KPs. A program manager from one implementing partner, Centre for the Development of People, said that the "gap analysis [we learned] was a new way of finding where the problem lies, and involvement of the peer outreach workers in finding solutions was very encouraging."

Learning. In Kenya, UOM and its in-country partners established learning sites to provide hands-on learning experience in KP-programming including establishing effective outreach, drop-in centers, clinics, and violence prevention and response services. Recently, the new LINKAGES Burundi team visited these learning sites in Kenya to learn more about clinical services for KPs.

Capacity-building. Acceleration teams also conduct three- to five-day thematic, country-specific workshops. Themes have included mapping, violence prevention and response, microplanning, data entry and quality assurance, and peer outreach. After the training workshops, based on the feedback from the participants, acceleration teams help tailor

programmatic tools and guidance to suit the country needs and then share the new versions with the countries for scale-up.

After a recent mapping workshop in Jamaica, one participant expressed enthusiasm for what he had learned. "We have done mapping before but the forms were too long and complicated. The community was also not involved like they are now. We certainly like this new methodology and would like to make it a regular part of our work."

*By: Parinita Bhattacharjee and Faran Emmanuel, University of Manitoba
Meg DiCarlo, LINKAGES, FHI 360*

University of Manitoba has long-standing experience working with KPs and, through its Centre for Global Public Health, has provided technical support and conducted high-impact projects, ranging from research to large-scale implementation.

1. World Health Organization (WHO). Technical Brief No. 3 - DRAFT 3, June 12, 2008: Scaling up health services: challenges and choices. Geneva: WHO; 2008.

TRANSFORMING THE HEARTS AND MINDS OF HEALTH CARE WORKERS

Just think for a moment about peoples' journey along the HIV cascade—from having knowledge and awareness of HIV and understanding HIV's modes of transmission and one's own personal risk factors to getting an HIV test and, depending on the result, adopting ongoing prevention efforts or enrolling and remaining in care and treatment. How people are treated by health care workers at every step of this journey will determine their health decisions and behaviors. We must never underestimate the power and influence of a health care provider who makes a client feel at ease, provides up-to-date information, ensures confidentiality, listens without judgment, confidently performs procedures, and carefully explains the benefits of taking medication correctly, returning for follow-up visits, and completing referrals.

LINKAGES is striving for this level of health care for KPs. Project partner IntraHealth led the development of *Health4All: A Health Workers' Training*

Guide for the Provision of Quality, Stigma-Free HIV Services for Key Populations.

The guide is used to educate, orient, and build the capacity of health care workers to provide quality, stigma-free HIV services to SWs, MSM, transgender people, and PWID. Given the plethora of existing training material that addresses this topic, *Health4All* is a compilation of the best, most up-to-date information and participatory exercises available. It is also closely aligned with the *WHO Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* to ensure that health care workers provide the highest standard of HIV care possible to KPs.

The training guide has four modules: (1) The Rationale for Services for Key Populations, (2) Heart and Minds: Quality Services for Key Populations, (3) Appropriate Services for Key Populations, and (4) Action, Change, Commitment. Modules 1, 2, and 4 address crosscutting themes such

as laws, stigma and discrimination, violence, gender, sexuality, and human rights. These modules can be adapted for different country contexts. Module 3 focuses on the priority clinical standards of care for each key population, improving health care workers' interpersonal skills during a client visit, and performing a risk assessment. The training is a four-day training of trainers and a three-day training of health care providers; however, the material can be adapted for longer or shorter trainings.

Through a group of multilingual training experts and key population members and in consultation with ministries of health, IntraHealth has translated and adapted the training material and trained 291 trainers in Angola, Burundi, Cote d'Ivoire, Haiti, Honduras, Mozambique, and South Sudan, with more trainings to follow soon in Indonesia, Mali, and the Eastern Caribbean. The overall response has been very positive. For most participants, this training was their first opportunity to learn about KPs, understand KPs' barriers to accessing services, and to reflect on their own feelings and attitudes about providing services to KPs. Topics like these are often excluded in pre-service curricula and some health care workers don't even know when they have served a member of a KP, because so few ever feel safe to disclose their identity.

I recently asked the group of training experts for their observations during the trainings—the issues that surfaced among participants and which training approaches worked well.

The topic that surfaced most often was health care workers' lack of awareness about gender and sexuality. This surprised trainers because they assumed that health workers would have been exposed to these issues at some stage in their careers.



Photo Credit: Courtesy of IntraHealth

Participants and trainers from a recent IntraHealth-led health care worker training in Angola.

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Also cited was limited knowledge about the unique health needs of KPs and the urgency for KPs to access HIV services to curb the epidemic. In one of the trainings, the issue of oral sex came up and not only was this topic considered taboo to discuss, but also a participant thought that oral sex meant having sex over the telephone. Health care providers must understand and accept different sexual practices and lifestyles and develop the vocabulary and confidence to talk about them with all of their clients. Otherwise, clients will never feel comfortable talking about their high-risk behaviors, and opportunities will be lost to provide procedures such as anal exams for men and women, STI treatment, referrals for family planning, and provision of pre-exposure prophylaxis.

The LINKAGES trainings offer a safe forum where health workers and members of KPs meet and talk about their sexuality and health needs, dialogue that is appreciated by both groups. In Burundi, for example, one trainer said, “a cathartic moment came during a panel discussion with a trans woman and a man who has sex with men. For many participants, this was their first exposure to people from these key population groups, and hearing directly from them gave participants an exceptional opportunity to rethink their attitudes toward key populations.” After a workshop in Angola, a trainer explained that “one of the great moments was to have Imanny, a trans woman, giving the presentation about gender, sexual identity, and sexual orientation. She spoke beautifully about her own experience and linking with concepts. It was really moving!”

The importance of bringing key population members and health care providers together during the training cannot be overemphasized. This training approach is critical to empowering KPs, breaking down stereotypes, and reducing stigma.

However, an experienced trainer is required to facilitate discussions (which can become very heated) and move the group from debate to plans for action that can be implemented after the training.

In Mozambique, this was one trainer’s experience:

“One participant said, ‘You know, I came here because I had to...but you must understand that this thing of men who have sex with men is really strange, and it is not well accepted in our culture, especially in the South...and you know...we didn’t have this ‘problem’ here before. It has been caused by globalization, and you won’t change my mind!’ Well, it was the first day of the training, and I told him that I was not there to change minds but only to invite them to think about their own reality and how together we can improve health care....On the last day of training, he said this during the evaluation session: ‘I would like to thank you for this wonderful training...I learned a lot about rights and HIV and how we can improve our health system, but what I’m really thankful for is that I learned to be a better human being and to respect our differences. This will change me for life.’ I must admit that listening to him brought some tears to my eyes because I also learned that we can touch peoples’ hearts and change realities by simple activities like this training.”

Despite difficulties and some uncomfortable moments during the training, all the trainers commented on the passion, determination, and optimism that participants have toward their work and their desire to improve the quality of HIV services for everyone, particularly KPs.

“I was surprised by how quickly the majority of participants were to judge key populations before the training and even showed it during the exercises,” one trainer said, “but they drastically changed their minds by the end. Lots

of them expressed their regrets and apologized for being harsh to the key population participants.”

Some health workers stood out from their peers, in their ease, comfort, and acceptance of KPs, and they served as a positive example to others. In South Sudan, for example, despite impossible conditions, one of the nurses at the military hospital shared her personal commitment to getting antiretrovirals to people in the North, where the supply had been cut off. She was willing to go on her own to ensure that the people living with HIV in that area received treatment. For her, how those people had contracted HIV was irrelevant.

By: Kate Stratten, IntraHealth International, with contributions from Boniface Sebikali, IntraHealth senior clinical training advisor, and training consultants Lucy Stackpool-Moore, Larissa Polejack, and Françoise Grossmann

BETTER DATA-BASED PROGRAMING: BUILDING M&E CAPACITY IN MALAWI

Most of us know a brilliant person who lacks the practical skills to get things done efficiently. Similarly, an organization with strong technical competence will still struggle to achieve its goals if its organizational skills are weak. Pact, a LINKAGES core partner, is building the organizational capacity of KP groups in program management, financial management, and resource mobilization. Pact defines capacity development as a continuous process that fosters the abilities and agency of individuals, institutions, and communities to achieve their goals and contribute to local solutions.

Pact's capacity development approach is rooted in the baseline understanding of local partners' unique needs and emphasizes learning by doing. This approach encourages KP networks and organizations to take ownership of and plan for their capacity development goals recognizing the unique contexts, experiences, skills, and knowledge that each group already brings to the table. One example of Pact's work under LINKAGES is the capacity-building efforts under way with the Centre for the Development of People (CEDEP) in Malawi.

CEDEP was founded in 2005 to address the health needs of men who have sex with men (MSM) through advocacy, outreach, and peer education programs. In 2015, CEDEP began working with LINKAGES by adapting the HIV treatment cascade framework and working with peer educators to provide KP-friendly HIV prevention and care services. Over the past year, CEDEP has made significant strides in its organizational capacity in areas such as finance, program delivery, human resources, and most significantly, monitoring and evaluation (M&E).

Perspectives from the field

A series of interviews conducted between January 30 and February 1, 2017 helped illustrate how LINKAGES and CEDEP worked together to improve

their M&E systems, which, in turn, have increased CEDEP's social capital and improved outreach to MSM communities in Malawi. Following are excerpts from interviews with:

- Elizabeth Mpunga, Social Behavior Change Communications (SBCC) Advisor, Pact Malawi
- Louis Banda Sr., M&E Advisor, LINKAGES Malawi
- Gift Trapence, Executive Director, CEDEP, Malawi

Q: How did Pact work with CEDEP to build its organizational capacity?



Elizabeth Mpunga (Pact):

Pact applied the Integrated Technical Organizational Capacity Assessment (ITOCA) tool adapted to the LINKAGES context to assess CEDEP's technical and organizational capacities. The ITOCA, which was carried out using participatory methodology with CEDEP, revealed M&E as a priority area for improvement.

Based on the outcomes of the ITOCA, CEDEP developed an institutional strengthening plan that prioritized developing their M&E capacity. Pact offered a suite of support activities to address this need. For one, Pact helped recruit, hire, and orient an M&E officer, a position that did not exist at CEDEP

prior to LINKAGES. Pact also worked directly with CEDEP's peer educators to introduce, adapt, and apply monitoring tools to collect data on reach and distribution of prevention materials (such as condoms and lubricants), store and file data at all levels, and analyze collected information to make programming decisions.

CEDEP and its peer educators had the opportunity to apply the M&E tools in the field with oversight and guidance from Pact's capacity development team. This is important because learning theory in a classroom is not sufficient to embrace the use of M&E tools. CEDEP applied and practiced M&E in everyday activities to meet their immediate needs and thus internalized and appreciated the value of informed decision making using data, which led to greater impact for communities.

Q: How have peer educators responded to an emphasis on quality M&E data?



Gift Trapence (CEDEP):

The M&E tools are a welcome change, but are also a shift from the traditional

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way of doing things. Historically, it has been simple to just distribute condoms. Now, we are also tracking treatment services and systematically collecting information on our beneficiaries. It took time for peer educators to understand and accept this change, given differences in experience and education levels. However, a combination of in-classroom and field trainings helped them apply M&E tools and be supported during the process.

Q: How has CEDEP's M&E capacity grown during your time working with the organization?



Louis Banda (FHI 360):

At the very beginning, CEDEP didn't have experience with M&E tools or a person assigned to M&E; there was no comprehensive methodology for collecting, managing, and analyzing KP data. With support from LINKAGES, CEDEP began using standard tools and assessing their information to make decisions. Now, for example, CEDEP facilitates monthly meetings with peer educators, where they present data on the number of KPs reached that month, preventive services provided, and, even more important, KPs not reached. In the following months, they use this information to prioritize reaching KPs

that were missed. This wasn't done before.

Q: Why has building a strong M&E capacity been important to CEDEP?

Gift: CEDEP has always believed in the need for sound data to help us track our progress. We cannot determine how much change we have effected in our communities without quality data, and we can only obtain quality data with a well-functioning M&E system.

Q: How has an improved M&E capacity contributed to CEDEP's programming?

Elizabeth: Strengthened M&E systems have allowed CEDEP to use an evidence-based approach to programming. For example, CEDEP now has information about gaps in reach of services to MSMs and adjusts programming to address those gaps. This has increased the organization's credibility with beneficiaries and donors, earning them compliments of partner organizations from Malawi to Washington. This will help CEDEP establish strong relationships and secure future funding.

Q: Is there a single accomplishment that has been a highlight for the organization?

Gift: I would highlight bringing on a qualified M&E specialist and passing on the importance of quality data to our peer educators. The peer educators at the grassroots level collect the data, so CEDEP needs their support in gathering quality information on uptake of services so that we can accurately follow the treatment cascade.

Q: Did Pact coordinate with other programs in Malawi?

Elizabeth: Before engaging CEDEP, Pact connected with existing in-country capacity development efforts, particularly those implemented by Counterpart International (STEPS Program), to avoid duplication of efforts. Along with FHI 360, the

organizations compared assessment tools, results, country and community priorities, and systems to ensure streamlined coordination. The three organizations continue to collaborate through meetings and shared insights to provide comprehensive technical and organizational support to CEDEP.

Q: What should CEDEP focus on next?

Louis: LINKAGES in Malawi has an electronic database to track individual KP members confidentially and securely on services received, upcoming appointments, change in location, and more. I hope to see CEDEP use this resource for more up-to-date tracking of beneficiaries.

Q: What institutional systems is CEDEP looking to strengthen in the future?

Gift: We hope to apply a similarly rigorous M&E approach to our programming on gender-based violence by collecting information on prevalence and working with our communities to address human rights violations. We would also like to use a similar approach in CEDEP's other programs, including our advocacy work.

*By: Diana Muratova, Pact
Elizabeth Mpunga, Pact Malawi
Louis Banda, LINKAGES Malawi
Gift Trapence, CEDEP Malawi*

THE PEOPLE @ LINKAGES: BRIAN WHITE

A public health, communications, and community development specialist with a focus on the impact of HIV on individuals and communities, Brian White joined LINKAGES as senior technical advisor for community strengthening in June. He works for Pact and is seconded to LINKAGES. His extensive experience in building programs to ensure access to HIV testing, counseling, care, and treatment has spanned the world. He has been a statewide coordinator for an HIV prevention and care program, director of a positive prevention program, and a capacity-building consultant for community-based organizations and global health programs related to HIV and key populations.



Photo Credit: Courtesy of Pact

What are your duties as senior technical advisor for community strengthening?

I provide technical leadership for community strengthening, including empowerment and engagement, related to our programs on HIV prevention, testing, treatment, care, and support. This includes supporting the development and review of guidance on peer navigation and work on stigma and discrimination, advocacy, and human rights. I lead Pact's work in countries that have asked for support in strengthening the capacity of community service organizations (CSOs) doing LINKAGES work. I work

with the financial, operational, program management, and technical teams in Washington, D.C., and in-country.

Is your work concentrated in specific countries?

I have a long-standing interest in the I currently work in Democratic Republic of the Congo, the Eastern Caribbean (Trinidad and Tobago, Bahamas, Barbados, Suriname), Haiti, Indonesia, Kenya, Malawi, and South Sudan. Work will begin soon in Cote D'Ivoire and Swaziland.

What attracted you to the LINKAGES project?

I am a gay man and have been living with HIV for 24 years, so I am happy to be working with my community. I am passionate about making sure all people have equal access to quality HIV services to stay negative, and if HIV positive, to receive excellent treatment, care, and support no matter who they are or what circumstances they face. Being able to continue my work on an HIV project that supports the health and well-being of our community around the world is important to me. I also strongly believe that programs must work with community, as this is the only way we are going to end this epidemic—and LINKAGES does this by engaging and empowering communities.

What progress has been made in the area of capacity building, and what is its significance to the success of LINKAGES?

The ability of CSOs to deliver quality, effective services across the cascade and beyond, including clinical, social, legal, and livelihood, is critical to LINKAGES' success because it is the connection between the community and trusted CSOs that enables the community to ask for and receive ongoing services. The use of the integrated technical and organizational capacity assessment tool (ITOCA) developed by Pact has been key for this capacity building. The assessment helps programs to define priorities, measure performance, determine impact, and use evidence for future plans.

LIFE FACTS

Degrees/Expertise: BA, Political Science; MA, Communications; proposal development, organizational capacity strengthening, community development

Global experience: Asia, North America, Pacific Islands, southern Africa

Languages: French, Japanese, Indonesian

Family: Single with extended family in Canada and the United States

Leisure Activities: Hiking, yoga, reading, cooking

Philosophy: Be happy and choose to do things that make you happy

What excites you most about your work at LINKAGES?

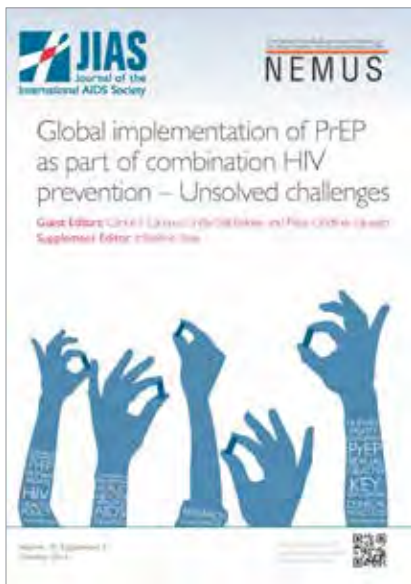
Meeting with our communities wherever I go is inspirational. In Indonesia I met with a people living with HIV (PLHIV) group, shared my experiences of living with HIV, and heard their stories of challenges and success in testing, accessing treatment, and staying healthy. We have stayed in touch. In Nairobi, I worked closely with community participants at the sex worker implementation tool (SWIT) workshop. They were knowledgeable and recognized the importance of sharing their experience by facilitating sessions and giving presentations. Their engaged participation made for better country plans, and they have an increased sense of ownership. Being part of and learning from community-led work is humbling and energizing.

What do you wish for key populations?

In the short term I wish for them to have access to quality health services free from stigma and discrimination. In the longer term, I want this epidemic to be over, and our human rights to be recognized—and then we won't have to be called key populations anymore.

By: Stevie O. Daniels, FHI 360

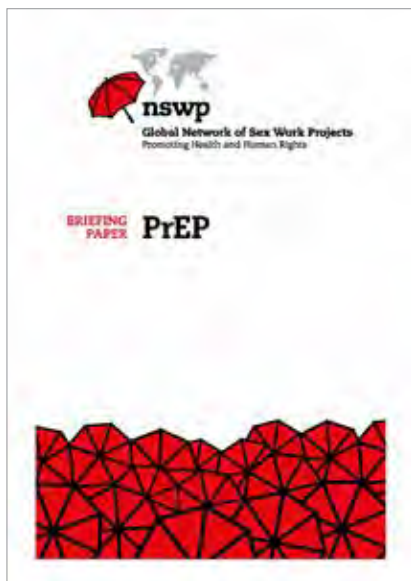
NEW RESOURCES: RESEARCH AND REPORTS



GLOBAL IMPLEMENTATION OF PREP AS PART OF COMBINATION HIV PREVENTION-UNSOLVED CHALLENGES

<http://www.jiasociety.org/index.php/jias/issue/view/1484>

This special supplement of the Journal of the International AIDS Society centers on the rollout of pre-exposure prophylaxis (PrEP) for HIV infection with a focus on regions not previously included: sub-Saharan Africa, Asia-Pacific, Latin America, and Europe, and on specific populations: transgender women, young people in the United States and South Africa, and people who inject drugs. Nine papers touch on such topics as identifying barriers and solutions, new implementation research, and preventing HIV among adolescents. This issue was organized by the Network of Multidisciplinary Studies in ARV-based HIV Prevention (NEMUS) with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS).



GLOBAL NETWORK OF SEX WORK PROJECTS (NSWP): PROMOTING HEALTH AND HUMAN RIGHTS

<http://www.nswp.org/resource/prep>

This briefing paper is an update and elaboration of NSWP's consultation with its membership over the use of PrEP and early treatment as HIV prevention strategies. It provides insight into what sex workers think about PrEP, what concerns they have about it—including legal barriers and side effects—and what actions should be taken before its introduction. This resource provides an in-depth and meaningful consultation with sex workers about PrEP and includes their key recommendations.



IMPLEMENTING COMPREHENSIVE HIV AND STI PROGRAMMES FOR MEN WHO HAVE SEX WITH MEN: PRACTICAL GUIDANCE FOR COLLABORATIVE INTERVENTIONS—NOW AVAILABLE IN MORE LANGUAGES

<http://msmgf.org/download-msmit-french-spanish-portuguese/>

Launched in 2015 by the Global Forum on MSM & HIV (MSMGF) and the United Nations Population Fund (UNFPA), this comprehensive guide—commonly referred to as the MSMIT—is now available in French, Portuguese, Russian, and Spanish. It outlines the design and implementation of HIV and sexually transmitted infection (STI) programs targeting gay and bisexual men and other MSM. This resource was developed for public health officials and program managers, as well as nongovernmental organizations and health workers implementing HIV and STI programs with gay men. The guide includes chapters on community empowerment, addressing violence against MSM, condom and lubricant programming, health care service delivery, communications, program management, and examples of successful programs. Other organizations involved include the United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank, Gates Foundation, and more than 100 experts from around the world.

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LINKAGES, a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID), is the largest global project dedicated to key populations. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.

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