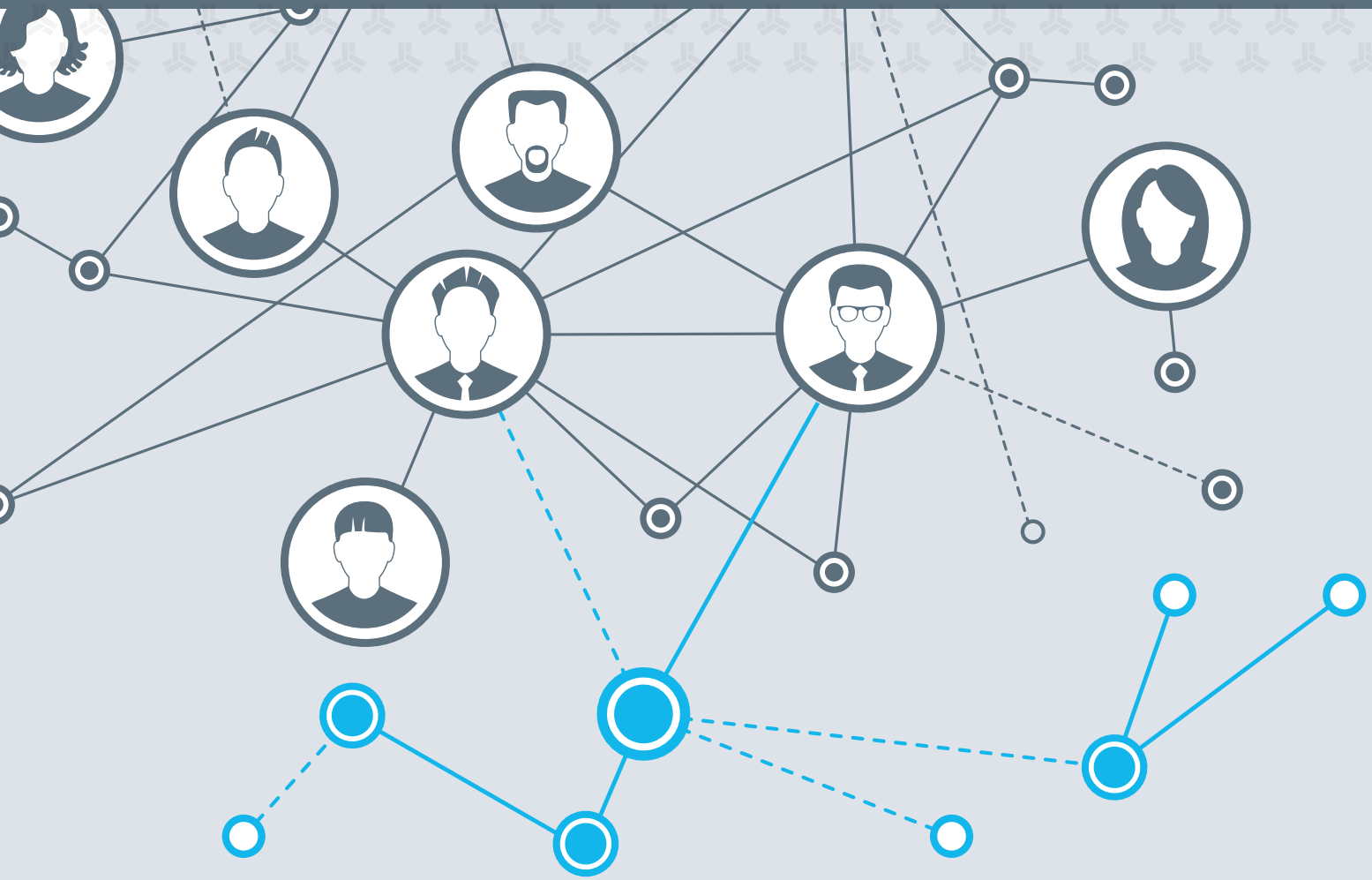

ADDENDUM

APRIL 2019

# LINKAGES Enhanced Peer Outreach Approach (EPOA)

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PEPFAR

LINKAGES
Across the Continuum of HIV Services for Key Populations

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THE SCIENCE OF IMPROVING LIVES

LINKAGES, 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—sex workers, men who have sex with men, people who inject drugs, and transgender people. 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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# Why is there an addendum?

There are four reasons why LINKAGES is providing this addendum to the EPOA guide.

1. During the abstract submission process for the International AIDS Conference, we found that many country programs were calling an activity "EPOA" even though all the necessary components of the approach had not been implemented (when all the components *are* implemented, we say that EPOA was implemented with "fidelity").

2. Several countries implemented EPOA with mixed results and were wondering why it was not more successful.

3. EPOA will continue to be implemented in FY19 and beyond, and it is good to continually improve upon activities to achieve better results.

4. Country programs are wondering how the use of risk network referrals (RNRs) differs from EPOA.

This addendum provides a refresher on what EPOA is, how the approach works, what criteria are used to determine whether EPOA is successful, what key components must be present for an activity to be considered "EPOA," reasons why EPOA might not be achieving the desired results, and how EPOA and use of RNRs are similar and different.

### Objectives of EPOA

- Close the gaps in access to testing, treatment, and prevention services among historically hidden and hard-to-reach key populations (KPs)
- Improve the capacity of outreach programming to adapt to new HIV transmission patterns and continuously improve outcomes over time
- Increase the capacity of outreach programming to meet the differentiated prevention, care, and support needs of KP members in the community across the entire HIV cascade
- Improve the efficiency of, and returns on, investments in outreach programming

## What is EPOA?

EPOA uses performance-based incentives and works through social and sexual networks to improve HIV case-finding outcomes. Trained peer outreach workers (POWs) invite members of KPs to become peer mobilizers (PMs). PMs, in turn, reach out to their social and sexual networks to encourage peers to get tested for HIV and seek other related services.

The approach was designed to extend programming beyond geographical areas given that stigma, discrimination, violence, and criminalization have driven many individuals facing the highest risks into hiding. The underlying hypothesis of "reaching the unreached" (which is increasingly supported by program experience) is that populations that have historically not benefitted from or participated in programming often have high HIV burden or substantial risk of becoming infected. It is these networks of un- or under-served individuals who are uniquely positioned to refer peers similar to themselves. Asking people living with HIV (PLHIV), and people at high risk for HIV for their leadership and support in extending testing to members of their networks is essential; therefore, EPOA implementation should strive to be pro-positive (i.e., programs and staff focus on the needs of PLHIV), client-centered, and PLHIV-inclusive.

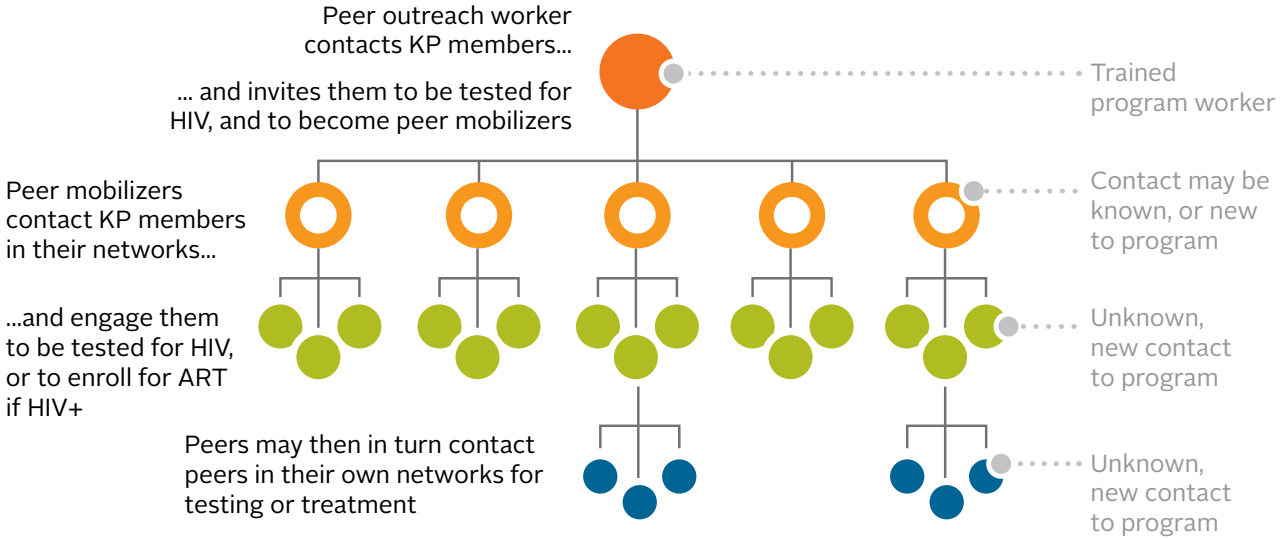
## How does EPOA work?

The approach is implemented through community-based organizations (CBOs) that have POWs delivering services to KP members in a variety of "hot spots," or physical locations in which KP members with an elevated risk of HIV are present. POWs are trained to reach out to these KP members and encourage them to be tested for HIV, and—depending on the KP members' level of HIV risk, social network size, communication skills, age, and location—invite them to become PMs. PMs then distribute coupons to their own peers who were previously unidentified by the program, who are hard to reach, and whose behaviors likely elevate their risk for HIV. The PMs refer these peers to a range of health and wellness services, most importantly HIV testing and treatment. (This "referral chain" is illustrated in **Figure 1**.) If peers know they are HIV positive but are not on treatment, they are encouraged to initiate or re-initiate treatment. Peers hand in the coupons when they present for services, allowing the program to track how many people each POW and PM has successfully referred and provide incentives accordingly.

To be most effective in reaching a wide variety of KP members, the peers engaged in EPOA should represent a range of different individuals from the vast and complex spectrum of KPs, such as older, non-gay identified, and/or married men who have sex with men (MSM). Female sex workers (FSWs) who are internet-based and of higher social-economic status are examples of different subgroups among the larger FSW community. Programs should determine which KP subsets they want to reach based on data, programmatic experiences, and plans.

Especially given that some HIV-positive individuals reached through EPOA will be having contact with the HIV program for the first time, services must maintain strict confidentiality and should provide appropriate social and navigation support. Staff should also be trained on how to provide more pro-positive, pro-KP, and high-quality services to increase antiretroviral therapy (ART) initiation and adherence.

**FIGURE 1. Expanding outreach through a referral chain**



### What determines EPOA's success?

The success of EPOA is not based on the number of "waves" of contacted peers (or number of referral chains) that a POW or PM generates, but instead on the number of newly diagnosed HIV-positive individuals—so, case-finding is the critical indicator of success. EPOA is focused on testing individuals with the greatest prevention and treatment needs, and case-finding is used as a proxy indicator to help ensure that EPOA is functioning within the highest-risk networks. Once PLHIV are identified, the program has a responsibility to link them to treatment and link others in their networks to relevant prevention and treatment services. Therefore, linkage to treatment is also a criterion for success. While a large number of waves may allow the program to get deeper into unreached networks, it does not necessarily guarantee higher case-finding rates. The program needs to track the PMs' referral chains because one PM may recruit many individuals who are new PLHIV (high case-finding) but not achieve multiple waves, while another PM may have multiple waves but a low case-finding rate. The program should not disqualify a PM with high case-finding just because multiple waves were not achieved. Multiple waves may or may not be useful, depending on whether PMs are recruiting the kinds of individuals who would most benefit from HIV services, or those who are HIV-positive but do not yet know their status. The incentive structures need to reinforce successful outcomes.

EPOA strives to:

- Stop continuously reaching the same social and sexual networks of KP individuals
- Complement traditional peer outreach by engaging previously unidentified KP members for HIV services—particularly those who are hard to reach and who may be at high risk of HIV acquisition, or HIV positive
- Focus on KP members who are not found at traditional hot spots

# What are the key components of EPOA?

**If any one of these components is absent, the activity is NOT EPOA. Implementing ALL of the components below is called implementing an intervention with "fidelity."**

1. **EPOA is performance-based** on certain criteria, such as new registration in the program, HIV testing and counseling, and ARV treatment. If certain performance-based criteria are met, then individual, group, or organizational incentives, rewards, or recognition are given.
2. **Incentives** (either monetary or nonmonetary) are provided to POWs and PMs for recruiting eligible clients to HIV services.
3. **Higher-risk** social and sexual networks (not just numbers, but results) are the priority. The careful selection, tracking, and pairing/coaching of POWs and PMs will help ensure that your program is reaching high-risk networks.
    - Selection, tracking, and pairing/coaching of **POWs.** Usually, there is a minimum performance measure for POWs. If the POW does not reach the minimum, then coaching and mentoring is necessary.

Underperforming POWs can be paired with successful ones (see Laos example in the adaptive management box below).

- Selection, tracking, and pairing/coaching of **PMs.**
  - The program should track the success of PMs' networks and encourage more successful PMs (e.g., measured by higher case-finding) to provide additional coupons to their friends, acquaintances, and/or sexual partners. Overall, do not limit the number of coupons given to a PM, especially if he or she asks for more. However, if a PM is not tapping into more-infectious networks, then these PMs can be phased out.
  - Encourage peers of PMs to also become PMs.
  - To the best of your ability, ensure that PMs are willing to distribute coupons, are good communicators, and have larger-than-average social/sexual networks who are at risk for HIV. Note that if PMs practice high-risk behaviors they may associate with peers who also engage in higher risk behaviors.
  - For successful PMs—Ensure that the program is providing them with more coupons to distribute. Have a POW follow up and maintain a relationship with the PMs to encourage their continued engagement in EPOA.
  - For less successful PMs—Try to improve their performance by having the POW encourage them to distribute coupons and remind them about the incentives they will receive if their peers seek services. POWs can also coach underperforming PMs on how to present and distribute the coupons, and where their peers can seek services.

**Do not provide incentives for case finding.** Even though EPOA success is predominantly about case-finding and linkages, not testing, we can't incentivize case-finding among peers given safety, security, and confidentiality risks. POWs and PMs receive incentives based on certain programmatic indicators, such as numbers of people newly recruited to the program, numbers eligible for an HIV test (i.e., not tested in the past 3 months), numbers of eligible people who received an HIV test, and ART initiation. **Note that HIV-positive serostatus is not an indicator for which a POW or PM receives an incentive, even if HIV-case finding is the program's goal.**

## Adaptive Management, Standard Outreach in Laos

The Laos program has a performance-based measuring system for their POWs. POWs are coded red, yellow, or green based on minimum criteria (e.g., five new KP members access HIV testing and counseling in a month). The program does not fire a POW for a bad month but rather pairs the underperforming POW with a successful POW. The successful POW coaches the underperforming POW for a couple of months and the performance is tracked. If the underperforming POW still has two quarters of low results, he or she is then asked to leave the program. Usually, the coaching improves results; only two or three POWs have been let go.

The same principles of tracking performance, following up, and coaching/encouraging "successful" PMs can be used to increase results.

4. **Clear links are offered** to prevention, testing, treatment, education, navigation, and support services that are provided in a safe, secure, and confidential environment.

5. **Data are collected and used**. Programs should continually collect and track results on what works, where, when, and with whom, especially which networks are generating higher case-finding.

6. **Quality improvement is prioritized.** The program should continually review data and performance and modify implementation accordingly (this is called "adaptive management").

## Stages of EPOA

1. *Cast a wide net:* EPOA intends to engage individuals and groups that the program is not currently reaching. If the program starts by casting a wide net geographically, selecting PMs from a variety of subsets of KPs from within the community, and providing the POWs and PMs with a large number of coupons, the EPOA may be more likely to achieve its goal (see box below).

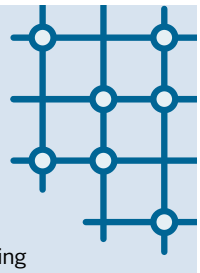
2. *Track:* Review data in real time and see what is working (that is, achieving an acceptable number of new HIV cases and links to treatment), where it is working, and with whom so that course corrections can be made as soon as possible.

3. *Narrow and focus:* Make decisions about where to focus your efforts based on data and ease of implementation. For example, you want EPOA to be conducted where services are available and accessible so those who want to access services can receive them, and incentives should be provided in a timely fashion so that POWs/PMs remain engaged and motivated.

4. *Direct:* When you've determined what is working well, implement again quickly to not lose momentum.

5. *Track and repeat:* For the long term, review data and trends, refine implementation, add complexities and nuances, and implement again.

### What do we mean by "wide net"?



EPOA intends to engage individuals and groups that the program is not currently reaching. Therefore, in one sense, "wide net" refers to the fact that there should be minimal restrictions on who can serve as PMs and how many clients they can recruit. The program should track the POWs' and PMs' data to determine which POWs/PMs are the more successful recruiters and which recruitment networks lead to higher case-finding. This tracking can be useful in two ways. First, programs can prioritize providing support to existing PMs who contribute more to program objectives and, second, over time recruitment of new PMs can become progressively more targeted as the program learns what PM characteristics (demographics, network size, risk behaviors, etc.) are associated with increased testing and case-finding.

A "wide net" can also refer to geographical locations in which EPOA is implemented. The program may be implemented in many sites at first, but subsequent rounds could focus on areas of higher case-finding to try and saturate reach in those areas. However, as noted above, we understand that social and sexual networks are not bound by geographic location. Thus, HIV programs should not attempt to impose strict geographical limits to peer-driven recruitment but should endeavor to provide services to people of highest need. This can be accomplished by working with private providers outside of PEPFAR-prescribed zones, mailing or distributing test kits to where individuals are located, and offering on-line counseling/referral services. EPOA strives to engage groups in the program that have not been reached and provide services to PLHIV who are not currently on life-saving treatment.

# We tried EPOA and it didn't work. Why?

There could be multiple reasons why EPOA did not work in your program, but the following are the most common.

- **Not extending beyond existing networks—** EPOA may not have been successful because it did not expand beyond the existing networks to which the outreach program was already providing services. The referral chain would be limited if the selected PMs were already part of the program and were also providing coupons to those already engaged. It needs to be clear from the beginning of implementation that at least some of the selected PMs be individuals who are not accessing HIV services. Then, as EPOA is being implemented and data are analyzed and used, PMs can be selected based on specific characteristics that have demonstrated results such as age, gender, risk behaviors, and geographical location.
- **Limited networks (POWs'/PMs' networks)—**Ideally, the program would have gauged the size of the KP population that it could potentially reach. Then, based on the population size and program coverage results, determine if there is potential to reach individuals not currently accessing services. The population size estimate could be done through a mapping/size estimation exercise of physical spaces, on-line network density mapping, or other means. If the size of the population is large and the program has not reached saturation levels, then EPOA would work. If the KP population is small or the program has reached most KP members in the population, EPOA may not reach its objectives. EPOA has had limited success where KP populations are smaller, closed, and/or the program has reached saturation.
- **Budget constraints—**If the program did not have enough funds to provide adequate incentives or personnel, EPOA may not be successful. Before implementation, KP groups and CBOs should be consulted on what type of incentive (within reach of your budget) would be most motivating for individuals to distribute coupons and encourage peers to seek services, and what staffing structure is necessary to ensure smooth operations.
- **Missing implementation elements—** Ensure that the EPOA in your program includes all six elements described above: 1) performance-based, 2) incentives (e.g., monetary/nonmonetary), 3) higher-risk social and sexual networks, 4) clear service delivery and referral to HIV services, 5) data collection and use, and 6) quality improvement.
- **Lack of data collection, monitoring, and tracking—**EPOA data should be collected and tracked on a weekly basis and used to troubleshoot. The program should track the coupon flow from a POW to PM to peer and determine the case-finding rate for each network. Then, based on case-finding results, additional coupons should be provided to successful PMs to ensure that the program is saturating their social/sexual networks.
- **Inadequate data analysis—**Data should be analyzed weekly to see, for example, which POWs and PMs are the most successful and/or which geographic area has the highest case-finding. Then, data analyses can be shared and discussed as a team, and next steps defined for future implementation.

## Key EPOA data points/indicators to be tracked

*Process-oriented indicators*

- Coupon rate—# distributed vs. # returned
- Time from PM distributing the coupon to a peer seeking services
- # of PM waves
- # of newly registered KPs into HIV program
- # of KP peers who were eligible for testing
- # tested

*Outcome-oriented indicators*

- HIV case-finding
- ART initiation

## Multiple terms, similar meanings: index testing, partner notification, and voluntary partner referral

In practice, index testing and partner notification are essentially the same (see *2016 World Health Organization [WHO] guidance*), but "index testing" is the umbrella term that extends "partner notification" to biological children. Here are some useful WHO definitions:

**Index testing:** often referred to as index case, index patient, or index partner HIV testing. This is a focused HIV testing approach in which the household, family members (including children), and partners of people diagnosed with HIV are offered testing.

**Partner notification services:** also known as disclosure or contact tracing. This is defined as a voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, and then, if the HIV-positive client agrees, offers these partners HIV testing services. Partner notification is done through passive or assisted approaches.


Passive referral is when the index patient prefers to contact and refer his/her partners themselves. The three active referral options are contract-referral (e.g., index patients refer partners on their own, but provider will contact the partners if they do not come after an agreed period of time), provider-referral (e.g., provider will contact partner), and dual-referral (e.g., couple comes together to get tested).

In all cases, disclosure of one's HIV status to a partner is purely voluntary. Providers are trained to offer support if PLHIV opt to disclose their HIV status to others, in light of the evidence that having a treatment supporter improves adherence to ART, likely enhancing its benefits. However, providers are also expected to counsel PLHIV on the potential risks of disclosure, and to screen out partners with whom there may be risks of intimate partner violence. The aim of all partner notification approaches discussed here is to put the needs of PLHIV first and address their personal treatment and broader health and well-being in the process of offering options for index-testing referrals. Doing so may help to increase the comfort of PLHIV to refer partners and network members.

If HIV-positive clients decide to disclose their status to their partners, the partners are contacted, and the provider offers HIV testing services. This approach typically results in high rates of case-finding but seldom leads to high numbers of referrals, because PLHIV may not feel comfortable with, or capable of, naming all their sexual partners and providing

associated contact information. This is particularly true for KP PLHIV, and hence the origins of risk network referral (RNR) described below.

While the WHO partner notification guidelines are intended for all PLHIV, they are not specific to the needs and circumstances that KP members face daily. To address this issue, LINKAGES held focus group discussions with KP members in the Dominican Republic. Participants wanted to emphasize the voluntary and noncoercive nature of contacting sexual partners. They also preferred the term "referral" versus "notification" to emphasize the client-centered approach in which the primary focus is on the person who is diagnosed with HIV and not on the process of notifying partners who may have been exposed to HIV. In response, LINKAGES developed the term "**voluntary partner referral (VPR)**." Consistent with WHO's global guidance on partner notification and referrals, a VPR approach presents PLHIV with the voluntary opportunity to identify spouses, partners, and children who may be at risk of HIV and offers the same four options described above (passive, contract, provider, dual) for referral of the named individuals to HIV testing and other services.

Other areas of emphasis in the VPR approach are safety and confidentiality, both of which are discussed during counseling with both the client and partners. Clients are also counseled on the risks and benefits of disclosure and are offered support for disclosure, but disclosure is never required.

LINKAGES also defined the **risk network referral (RNR)** approach, which seeks to expand the potential benefits of index testing among KPs by: 1) providing an expanded set of self-led referral options according to the KPLHIV's preferences; and 2) expanding KPLHIV referrals to other network members beyond sexual partners, injecting partners, and biological children through coupon-based and online referrals. RNR does not require KPLHIV to name — or even know the names of — these contacts to make referrals. Through the RNR approach, KPLHIV distribute coupons to those in their social and sexual networks. Information communication technology (ICT) approaches also can be used to extend referrals. For example, a system could be set up that would allow KPLHIV to enter the phone numbers of their contacts. The contacts would receive a text message with a link to a website where they could make an appointment for HIV testing or could even connect members of their networks to HIV self-testing by making referrals or distributing HIV self-testing kits. These RNR strategies allow PLHIV to make these referrals without disclosing the referral source. Both VPR and RNR seek to tailor traditional index-testing approaches to make them more relevant and attractive to KPs.

## How are EPOA and RNR similar?

Both EPOA and RNR:

1. Are peer-led strategies to accelerate epidemic control by improving HIV prevention, testing, case-finding, and treatment linkage outcomes

2. Offer KPs an expanded, easy, self-led, and even anonymous option for making online, mobile-technology-mediated, and coupon-based referrals of a broader set of network members who they believe may benefit from HIV services

3. Can include referrals from high-risk HIV-negative individuals, should this have strategic prevention and treatment benefits and help to prevent inadvertent disclosure of serostatus

4. Can engage cadres of staff from the clinical, community, and virtual spaces

## How do EPOA and RNR differ?

EPOA expands the scope, impact, and efficiency of *outreach programming* in community settings.

RNR *engages PLHIV in voluntary partner referral* in clinical, community, and virtual settings (also see **Table 1**). Both EPOA and RNR are peer-led, but the two have differing, if overlapping, criteria.

Benefits of RNR are that:

- There is an opportunity to be increasingly targeted, because POWs recruiting PMs in outreach settings, as in EPOA, usually do not know the client's HIV status, but in RNR the HIV staff person would know the status of the KPLHIV.
- High-priority clients may have been reached by a POW previously and declined to become a PM in EPOA, but RNR offers an opportunity to re-engage them.
- EPOA targets outreach clients specifically, whereas RNR presents the opportunity to extend peer-driven recruitment to clinic walk-in clients.

**TABLE 1. Differences between EPOA and RNR**

| | EPOA | RNR |
|---|---|---|
| **PRIMARY OBJECTIVE** | A strategy to expand the scope and impact of outreach and testing services to improve their impact and efficiency. Case-finding is the primary outcome measure. | A strategy to expand the scope and impact of VPR. Case-finding, ART initiation, ART adherence, and viral suppression are the primary outcome measures. |
| **REFERRAL METHODS** | Focuses on community engagement of PMs in high-risk networks in making coupon-based referrals of their network members. | Focuses on engagement of PLHIV in community, clinical, and virtual settings in referring their network members through a variety of physical, mobile, and online strategies according to their preferences. |
| **ENTRY POINT** | Outreach | Multiple: outreach, testing, diagnosis, care registration, treatment initiation, community and clinical support, viral load testing. |
| **DISCLOSURE** | HIV serostatus of the POW and/or PM may not be known by the program staff and/or peers. | HIV serostatus of the index client is known by program staff who are providing services to that client. |
| **EMPHASIS** | Expanding reach to KP members who have not engaged in the HIV program before. | Client-centered approach where the KPLHIV are the priority, and ensuring their health and well-being is the focus. Staff offering RNR must have the capacity to provide navigation and at least link the client to relevant support in the process of offering options for referrals of network members. |

# Key Terms

## What is an "elevated risk of HIV infection"?

- It is when someone engages in higher-risk behaviors that put them in possible contact with the HIV virus through bodily fluids (i.e., blood, semen, vaginal fluids). Examples of risk behaviors include having multiple sexual partners, having unprotected sex, and reusing/sharing needles for injecting drugs. Individuals can also be at an elevated risk of HIV infection if they have sex or share needles with a partner who engages in higher-risk behaviors.

## What is a "higher-risk social network"?

- Often, individuals associate with peers who engage in similar behaviors as they do. Behaviors could include working in a similar field, playing in a similar sport, or enjoying the same hobby. They could also include behaviors that put them at risk for HIV, like drinking a lot of alcohol, having sex with multiple partners, having sex in exchange for money, and not using condoms.

## What is a "successful" peer mobilizer in EPOA?

- A "successful" PM is one who distributes coupons to their peers who subsequently seek and are eligible for the HIV services. Incentives are provided to a POW and PM if a peer in their recruitment chain is both eligible and receives the HIV service. This is the first level of success. The second level of success is for the program to determine and is based on the number of individuals newly registered, diagnosed with HIV, and initiated on ART. Data analysis and use are needed to 1) determine if a POW and PM recruitment chain was successful in increasing demand for HIV services, and 2) if the performance-based indicators were improved.

## What does "fidelity" mean?

- The "fidelity" of a specific intervention means that it is implemented to a level or degree of exactness in line with the original design or intention. For program to say that they are "implementing EPOA," then it must contain the six components listed above (i.e., performance-based, incentives, higher-risk networks, clear links to services, data collection and use, quality improvement). If the program is not implementing all six elements, then it is a variation of EPOA but not EPOA.

# Question & Answer

## 1. Should EPOA be continual or time-bound? How often should EPOA be conducted?

It depends. Many LINKAGES/Asian countries have incorporated EPOA into their outreach activities as a standard package, whereas the other LINKAGES countries are implementing EPOA in a time-bound fashion. Each program should implement EPOA as frequently as possible given their human and financial resources, the size of the potential KP community, CBO preferences, availability of commodities, and other key contextual and programmatic factors. Small KP communities most likely do not need continuous EPOA because networks can become saturated, but larger KP communities may benefit.

## 2. How do we integrate the principles of EPOA into routine programming?

Please see the section on "key components of EPOA" for the main principles that are necessary to integrate into the routine program.

## 3. Do I only give three to five coupons?

The program can start with distributing three to five coupons, and then give PMs more once those have been returned. Also, if a PM is still motivated and engaged in the activity, and willing to continue to distribute coupons, then giving them more coupons to saturate his/her sexual or social network may be effective.

## 4. How do we decide what incentives to provide?

Incentive decisions should be based on what your program's budget can realistically support. You should also consult with the KP community about what incentives would be most motivating.

## 5. Who receives incentives and for what?

Traditionally, POWs and PMs receive incentives based on certain programmatic indicators, such as numbers of people newly recruited to the program, numbers eligible for an HIV test (e.g., not tested in the past 3 months), numbers of eligible people who received an HIV test, and ART initiation. **Note that HIV-positive serostatus is not an indicator for which a POW or PM receives an incentive, even if HIV-case finding is the program's goal.** However, the program may want to provide rewards to program teams or staff for running an EPOA that optimizes case-finding by adaptively selecting and reselecting the right peers. That said, this is categorically different from giving PMs incentives for case-finding.

## 6. How quickly should I give the incentives to POWs and PMs?

The quicker you can provide the incentives the better. Usually, incentives are given on a bi-weekly or monthly basis. It is important to communicate the timeframe of incentive receipt to POWs/PMs so they know what to expect.

## 7. When should the program provide incentives or stop giving monetary incentives?

A key component of EPOA is incentives, but the incentive does not have to be monetary. Nonmonetary incentives could include movie tickets, airtime for cell phones, and meal coupons. Another example of a nonmonetary incentive is an organizational incentive such as recognition to the highest performing CBO during a quarterly meeting with a certificate, or individually congratulating a higher-performing PM during an event. One country program decided to stop giving monetary incentives after they found that many ineligible peers were coming to the HIV services based solely on the incentives. After monetary incentives were removed, POWs/PMs were intrinsically motivated to refer their peers to HIV services based on eligibility (e.g., not tested in the past 3 months or dropped out of ART) and need (e.g., high-risk behaviors).

## 8. Where should services be located?

Our goal is to maximize service use by the KP community. Therefore, services should be located where KP members prefer to access those services. We should also offer differentiated services so enough options are available to meet a variety of needs.

## 9. How do we select successful POWs and PMs?

POWs and PMs are selected from within a KP group based on their willingness to distribute coupons, level of HIV risk, social network size, communication skills, age, and location. However, you will not know if they are successful until you collect data and track their networks to determine if they recruited someone who was a KP member, eligible for the HIV service, and tested HIV positive. If a PM does recruit someone who was HIV-positive or needed to be re-initiated on treatment, the program could work with that PM more closely to try and saturate that person's network. Peers in that PM's network should also be encouraged to become PMs.

## 10. How do we keep successful PMs in the program?

Your program is collecting, tracking, and analyzing data and can see that certain PMs are successful in recruiting eligible KP members who are more likely to be HIV positive. You should then reach out to those PMs, give them more coupons, and encourage them to hand out the coupons to others in their sexual and social networks. You should also ask them to encourage their contacts to become PMs. In addition, a specific type of incentive or the chance for a PM to become a POW may motivate PMs to remain engaged.

## 11. How do you support an unsuccessful PM?

To try and improve PM performance, the POW can encourage the PM to distribute coupons to their peers and tell PMs about the incentives that they will receive if one of their peers seeks HIV testing and is eligible for a test. The POW can also coach the PM on what to say to peers when giving them a coupon. However, if the PM continues to be unresponsive or unsuccessful, then this PM should be phased out and another PM should be recruited.

## 12. When should you phase out a POW from the program?

Adaptive management is when the program works with less successful POWs to support them to become more effective. This can be accomplished several ways, such as by pairing a less successful POW with a successful POW to coach him/her on how to improve performance or discussing his/her work style to see if solutions can be found. While most POWs improve their performance, there may be some individuals who do not improve and will need to be let go from the program.

## 13. Why should I keep track of the number of KP individuals who seek HIV services from certain POW/PM networks?

One of the key objectives of EPOA is to reach networks of KP members who are not accessing HIV services and who would benefit from those services. Tracking which peers come from which POW/PM networks, and then recording the peers' eligibility for services, receipt of services, and their HIV serostatus will enable the program to reengage successful POWs/PMs to continue their recruitment. Data tracking and analysis will also allow the program to follow up with less successful PMs to encourage and coach them to improve and/or find other PMs who are willing to engage in the EPOA.

## 14. Where do I get tools for analyzing EPOA data?

For routine analysis of EPOA data, you can use the standardized tool developed by the LINKAGES Strategic Information division. However, the tool needs to be customized to the specific programs based on their incentive schemes and the variables used for tracking EPOA performance.

If you have any additional questions, please contact Tiffany Lillie, tlillie@fhi360.org.