

LINKAGES India EPOA Practice Brief

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Background

India has the third largest HIV epidemic in the world, with 2.1 million people living with HIV (PLHIV) as of 2017.¹ The country's epidemic is concentrated among key populations (KPs)—female sex workers (FSWs), men who have sex with men (MSM), hijra/transgender (trans) people, and people who inject drugs (PWID). The HIV prevalence among these KPs ranges from 1.56 to 6.26 percent, compared with 0.28 percent among clients of antenatal clinics, who are considered a proxy for the general population.

The National AIDS Control Programme (NACP) has made a concerted effort to reach KPs with HIV services through targeted interventions (TIs),² which are implemented through nongovernmental organizations or community-based organizations and offer a standard package of prevention and care services to KPs. However, without reaching the KP individuals in India who are not accessing TI services and are not being reached through the national program, it will be impossible to end this concentrated HIV epidemic.

India is committed to achieving the UNAIDS 90-90-90 targets—that by 2020, 90 percent of all PLHIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART), and 90 percent of all people receiving ART will have viral suppression. Currently, as per the National Strategic Plan for HIV/AIDS and STI 2017–2024 of the National AIDS Control Organisation, only 77 percent of all estimated PLHIV in India know their status. This leaves a gap of 13 percent of PLHIV who need to be identified before the first 90 goal can be attained. In addition, of the 1.62 million PLHIV who have been identified, only 1.1 million, or 70 percent, are on ART.³

The 13 percent of people remaining to be identified as living with HIV are considered “hidden” and have been difficult to reach through traditional outreach channels and TI services. This is because of KP individuals’ reluctance to use HIV services for fear of being stigmatized, their preference for anonymity, their unwillingness to reveal their sexual orientation and practices outside of their own networks, their preference for seeking sexual partners on social media rather than at the physical hot spots where outreach-based TI services operate, and the fact that the TIs do not cover all geographical areas where KP networks might be found. While the NACP has made considerable improvements in slowing down the epidemic, reaching the 90-90-90 targets by 2020 will require reaching the hidden KP networks.



Photo credit: Burocraft for FHI 360

To address these challenges, the Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project, funded by the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and led by FHI 360, piloted an innovative approach called the enhanced peer outreach approach (EPOA) in six high-prevalence districts of India. EPOA seeks to access hard-to-reach networks of KPs to offer HIV prevention, testing, and treatment services by tapping into virtual and physical referral chain networks in ways that ensure the privacy of KP members.

What is EPOA?

EPOA is a peer-led referral network approach that follows the principles of respondent-driven sampling—a method used to reach a community-based sample of hard-to-reach populations for HIV surveillance. In this approach, KP individuals historically not reached in TIs are contacted by trained peer outreach workers, either through personal contacts at physical hot spots or other venues in the community, or through messages posted on social media. They are then offered HIV counseling and testing (HCT) at convenient locations and times through community-based HIV services. Those who test positive are helped to attend or are accompanied to government-supported integrated counseling and testing centers (ICTCs) for confirmatory testing. If confirmed positive for HIV, they are linked to nearby ART centers for treatment initiation. Individuals who test negative are given prevention counseling and commodities (i.e., condoms and lubricants). Eventually, once pre-exposure prophylaxis (PrEP) implementation has begun, HIV-negative individuals will also be offered PrEP.

In EPOA, KP individuals who access HCT may be recruited as “primary seeds,” or first-wave peer mobilizers (PMs). **A good candidate for a seed is someone who has a large social or sexual network, is a good communicator, and is willing to enroll peers from his or her network** who are interested in taking up the HIV services offered. Interested peers mobilized by the primary seeds can then be engaged as secondary seeds to enroll peers in their networks, thus creating subsequent waves of PMs and KP members reached. This referral system is incentive-based in that PMs are provided with travel reimbursements to give to clients who complete their referrals.

Snapshot of EPOA

- Adapted from respondent-driven sampling for HIV surveillance
- An incentive-based approach that creates successive waves of referrals for HCT
- Maintains privacy of KPs and reaches “hidden” KP members in physical spaces and through online media
- Has achieved a 14 percent case-detection rate among hard-to-reach KPs in India
- Is scalable at the national level in India by leveraging existing resources

How was EPOA Implemented?

EPOA was piloted in Mumbai, first through a virtual approach and later in physical hot spots. It was then scaled up to the other districts covered by LINKAGES India. Examples of the virtual and physical forms of EPOA as implemented in India are described below.

VIRTUAL EPOA: EXAMPLE FROM MUMBAI

For virtual EPOA, an effort known as Project Mulakat was implemented by LINKAGES India, in collaboration with the Mumbai District AIDS Control Society and the community-based organization Humsafar Trust. It targeted MSM who use social media to solicit sex in Mumbai.

The eligibility criteria for the EPOA participants were that they be MSM, be at least 18 years of age, have accessed social media to solicit male sexual partners in the preceding three months, have had sex with a man in the previous month, and have never availed services from or registered with the TI program.



Photo credit: Burocraft for FHI 360

As part of EPOA, three Internet outreach workers were hired to send messages to recruit primary seeds via the social media platforms Facebook and PlanetRomeo. Each outreach worker was tasked with identifying seven potential primary seeds who fulfilled the eligibility criteria and then recruiting them into the program. After these primary seeds underwent HIV testing at the HCT center, they were approached for their willingness to participate as PMs.

The primary seeds who consented to be PMs and fulfilled the eligibility criteria were then given a fixed number of coupons by a coupon manager stationed at the HCT site. Primary seeds were instructed to give these coupons to their peers who were using social media to solicit partners and who were interested in availing HIV testing services. The seeds connected with their peers through social media, met them physically, gave them the coupons, and referred them to the HCT center for testing. For successful referrals—when the referred individual reached the intervention facility and accessed HIV testing—the referring seed and the referred seed were both provided a monetary incentive (i.e., reimbursement for their travel and logistical costs). Further, if the referred individual consented to be a PM, the coupon manager provided him with a fixed number of coupons to distribute to his peers who were using social media to solicit partners, thereby creating subsequent waves of seeds (secondary seeds) and networks.

The coupon manager at the HCT center was responsible for managing the coupons. Every two days, the Internet outreach workers provided the coupon manager with the names of individuals recruited as PMs, their contact details, and the number of coupons allotted to these recruited PM seeds to track their referrals. Each coupon was also assigned a unique identifier code for tracking the referral network. The coupon manager was then tasked to do the following:

- Distribute the coupons
- Confirm the referrals by tracking each client's coupon (upon the client's arrival) using its individual identifier, updating the EPOA register with the "arrival status of the client" under the respective PM, and confirming the screening criteria for eligibility. If eligible, the client was enrolled under EPOA; if ineligible, the client was counseled and then referred to the nearby TI national program facility.
- Facilitate the clients for testing at the HCT center, which involved guiding each client on the client flow at the HIV testing center (Figure 1) and accompanying the client to the counselor for pretest counseling
- Conduct peer navigation to help those who test positive get confirmatory testing and initiate treatment

As the network grew, the coverage of HIV testing services likewise increased, thereby reaching more previously hidden individuals who did not know their status.

Figure 1. Client flow for virtual EPOA in Project Mulakat



PHYSICAL EPOA: EXAMPLE FROM ANDHRA PRADESH

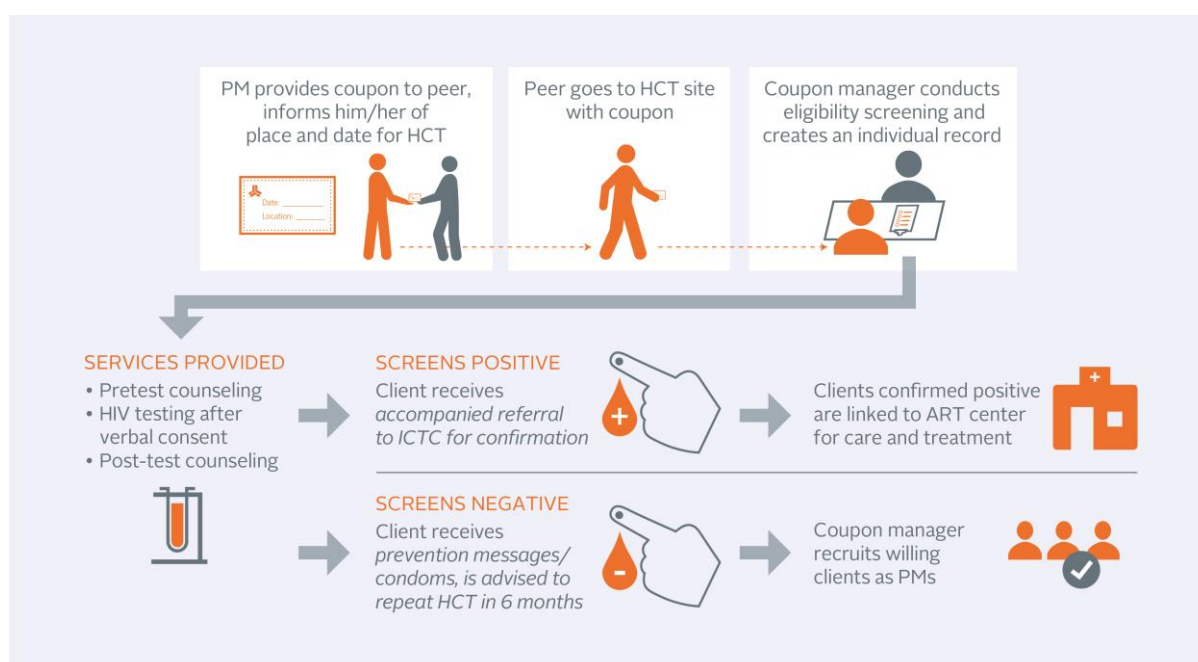
The physical version of EPOA was implemented in Andhra Pradesh by LINKAGES India, the Andhra Pradesh State AIDS Control Society, the District AIDS Prevention and Control Unit, and the nongovernmental organization RIDES in three subdistrict units of Krishna District (i.e., Machilipatnam, Nandigama, and Vijayawada).

The eligibility criteria for EPOA participants in these sites were that they be MSM or trans people, be at least 18 years of age, have had anal sex in the previous six months, and have never registered with the TI program.

A peer outreach worker was identified and hired as the coupon manager for each “cluster” (i.e., the term for each geographic coverage area used in EPOA implementation) and was given a monthly honorarium. The first role of the coupon manager was to identify PMs who might become primary seeds by engaging with the peers in their networks to motivate them to attend community-based testing (Figure 2). The individuals who got tested for HIV and agreed to refer other KP peers in their social and sexual networks for HIV testing services then became PMs and primary seeds. Approximately six primary seeds were sought per cluster.

The primary seeds contacted, motivated, and referred their peers for HCT at a convenient location in the community using the same coupon-based referral system as in virtual EPOA, with coupon managers providing the referral coupons and travel expenses to PMs for referring peers from their networks. Any peer mobilized by the primary seeds who was willing to be enrolled as a PM (i.e., as a secondary seed) was then provided coupons to give to peers in his or her network. PMs were incentivized if their peers accessed services at ICTC/ART centers, and peers who accessed services were also reimbursed for their travel costs.

Figure 2. Client flow for physical EPOA in Andhra Pradesh



PROGRESS TOWARD EPIDEMIC CONTROL

Following piloting, LINKAGES conducted EPOA across multiple sites of the PEPFAR priority districts in Maharashtra (i.e., Pune, Thane, and Mumbai) and Andhra Pradesh (i.e., Krishna, Guntur, and East Godavari) from October 2017 to March 2019.

Though the virtual and physical approaches to EPOA described above pertained to EPOA sites targeting MSM and trans people, other sites also included FSWs and PWID.

Through virtual and physical EPOA with all KPs, the project reached and tested 8,061 individuals, identified 1,101 PLHIV, and initiated 1,035 (94 percent) of these PLHIV on treatment. The overall case-detection rate was 14 percent, with variations across sites and KP types. The highest rate of case detection was 15 percent (787/5,186 tested) among MSM, followed by 12 percent (246/2,136 tested) among FSWs, 11 percent (19/176 tested) among PWID, and 9 percent (49/563 tested) among trans people. The overall case-detection rate of 14 percent in populations who were previously difficult to access and who might stand to benefit from services is a ray of hope for efforts to reach the goal of HIV epidemic control.



Lessons Learned

During the implementation of EPOA, several important lessons emerged:

- **Regular monitoring and course corrections:** Partners and collaborators monitored EPOA processes and outcomes, such as growth of networks and HIV case finding, on a weekly basis. This resulted in important modifications during the project. For example, in the virtual approach for Project Mulakat, when recruitment of primary seeds took longer than anticipated, the online outreach was expanded to include messages on Facebook, in addition to those on PlanetRomeo.

Another challenge was that many people in both virtual and physical EPOA were not seeking services and returning their coupons. To address this, infotainment events combining entertainment (e.g., music, dance, and cultural activities) and information about HIV prevention and testing were organized at locations convenient for community members. PMs encouraged their peers to attend the events and present the coupons for services. Through this initiative, reach and testing increased.

A third course correction involved the number of coupons given to the PMs. The initial plan was to give a fixed number of coupons (usually four) to each PM; at a later stage, PMs who said they had a larger network were given more coupons upon request.

- **Convenient location of testing sites and same-day test results:** Experience has shown that it is easier to persuade KPs to avail HIV screening at community-based locations than at ICTCs. This is probably because of the ease of access and assurance of privacy at community-based locations. In addition, providing test results at the same visit avoids loss to follow-up of individuals who may not return for results at a later date.

To enhance EPOA coverage, it is recommended that TIs conduct HIV screening at community-based locations on predetermined days and times. Only those reactive to the screening test would need referrals to the ICTC for confirmatory testing.

- **Continuous focus on high-risk networks:** EPOA focuses on individuals at high risk who have the greatest prevention and treatment needs. Once identified, PLHIV should be linked to treatment, and other members of their networks should be linked to relevant prevention and treatment services. Success of EPOA is measured not only by the number of individuals tested (reached), but also by HIV case finding and linkage to treatment. After the initial phase of setting up EPOA in a particular area, peer outreach workers were trained and supported by technical specialists from FHI 360 and technical coordinators from the implementing subpartners to analyze data and penetrate further into networks of PLHIV and individuals with other known high-risk characteristics, such as low condom use, having multiple concurrent partners, and having a sexually transmitted infection.
- **Continuum of care:** EPOA provides a one-time service for HCT and linking PLHIV to ART. However, all KP members need regular services—PLHIV need ongoing support for retention in care and treatment, while HIV-negative individuals need prevention services in order to remain negative and should get retested at regular intervals. Ongoing services should be customized according to the preferences and needs of clients. The global experience of innovative programs that use communication technologies can be used to develop a combination package of online and face-to-face interventions for KPs with access to social media and personal mobile phones.

TESTAMENT TO LIVES AFFECTED



Photo credit: Burocraft for FHI 360

There is no question that EPOA has increased the reach of HIV programs in India, but even more notable is that it has done so through its attention to human connection. Because belonging to the same KP is no guarantee of mutual trust, the hard work and dedication of KP members involved in EPOA are to be credited with making the difference. A peer navigator spoke of the personal rewards of playing a role in EPOA:

I initially brought two people, one of whom tested positive. I didn't realize how powerful my small effort would be, as he now has a chance to get proper treatment and hopefully a better life from here on out. The process of testing was so easy, and the additional information on prevention practices was very helpful. I want to continue making this difference!

Through EPOA, KP members are helping each other to overcome the fear, and often reality, of stigmatization in health care settings and communities, as described by this coupon manager:

I am currently living with HIV and have had my fair share of problems being who I am. No one told me about this disease when I was young, and I have lost too many friends along the way, which is why it is my mission in life to help protect others like me, especially the younger generation. Today, I work as a coupon manager for the EPOA program. As part of my job, I visit friends and acquaintances at their homes or discreetly at their workplaces and even hot spots to educate them on the risks of not getting tested regularly. With such a community, building rapport and trust takes much effort, as many are trapped in a life of constant fear of discovery and stigmatization.

EPOA has created a sense of confidence and trust based on empowerment and ownership, as those who have often felt vulnerable themselves become agents of change among the people they know. The result is a growing referral network and more people than ever who are being helped to prevent and treat HIV.

Going Forward

Identifying and reaching hard-to-reach members of KPs is a priority for the current National Strategic Plan for HIV/AIDS and STI 2017–2024, as these individuals are at higher risk of HIV and more likely to transmit the virus to others than are KP individuals receiving regular services from TIs. LINKAGES' implementation of EPOA in Andhra Pradesh and Maharashtra has demonstrated that EPOA is an effective strategy for identifying and reaching previously unreached KP networks, providing HIV testing, and linking newly diagnosed PLHIV to treatment services.

For the NACP to adopt EPOA as part of its TIs, some customization may be necessary as per the situation on the ground. For example, depending on the number of unreached KP members:

- One or more peer outreach workers could be redesignated and trained as EPOA peer outreach workers.
- Peer navigators could provide support to PLHIV and linkage to ART centers.
- HIV screening should be provided at community-based locations by trained TI staff.
- PMs could be given monetary or nonmonetary incentives, which would require additional budgetary allocations to the TIs.
- The TI project coordinator and program officer for the technical support unit could be responsible for managing and monitoring EPOA activities.
- Existing personnel and other resources could be leveraged to minimize additional costs.

EPOA reaches hidden populations through a referral chain network, addressing their fear of stigma by safeguarding their privacy and establishing trust. Through EPOA, LINKAGES is able to tap into new social and sexual networks of KPs who are not being reached by TIs. Integrating EPOA into the NACP-supported TIs would enhance the coverage of KPs through the national program by improving case detection and addressing the testing and treatment gap, thereby inching toward achievement of the 90-90-90 targets.

¹ National AIDS Control Organisation. HIV sentinel surveillance 2016–17: technical brief; December 2017.

¹ National AIDS Control Organisation; Ministry of Health & Family Welfare, Government of India. National strategic plan for HIV/AIDS and STI 2017–2024: “Paving way for an AIDS free India”; 2017.

¹ National AIDS Control Organisation. Monthly progress report; January 2019.



References

¹ National AIDS Control Organisation. HIV sentinel surveillance 2016–17: technical brief; December 2017.

² National AIDS Control Organisation; Ministry of Health & Family Welfare, Government of India. National strategic plan for HIV/AIDS and STI 2017–2024: “Paving way for an AIDS free India”; 2017.

³ National AIDS Control Organisation. Monthly progress report; January 2019.

