PACTE-VIH Replication Toolkit:

Strategies and Resources for Implementing HIV Prevention, Care, and Treatment Programming with Key Populations in West Africa.

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PACTE-VIH

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Written by: Trinity Zan[1], Tara Miller[1], Jean Paul Tchupo[2] and Virginie Ettiegne-Traore[2]

[1] FHI 360, Durham, North Carolina
[2] FHI 360, Accra, Ghana

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LIST OF ACRONYMS

ART	Antiretroviral therapy
BCC	Behavior Change Communication
DIC	Drop-in Center
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IPs	Implementing Partners
KP	Key Population
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men Who Have Sex with Men
NACC	National AIDS Control Committee
NGO	Non-Governmental Organization
PE	Peer Educator
PEd	Peer Education
PLWH	People Living with HIV
PMP	Performance Monitoring Plan
SBCC	Strategic Behavior Change Communication
SMS	Standard Messaging Services (text messaging)
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV/AIDS
UIC	Unique Identifier Code
VCT	Voluntary Counseling and Testing Services
WAHO	West African Health Organization

PACTE-VIH REPLICATION TOOLKIT INTRODUCTION

BACKGROUND

Although HIV prevalence in the general population in West Africa is relatively low (at approximately 2.5%), the prevalence among key populations is significantly higher. Female sex workers (FSWs) and men who have sex with men (MSM) have an HIV prevalence of up to 30 times higher than the general population in this region. High prevalence and low rates of retention in care can be attributed to multiple factors, including low levels of testing, no knowledge of HIV status, behavioral risk factors (such as multiple sexual partners and low condom use), and the political and structural environments in these regions (including policies and legislation that criminalize homosexuality and sex work).[1] Together, these factors significantly limit access to competent, friendly services for key populations throughout West Africa and demand a comprehensive, multi-faceted response.

PACTE-VIH PROJECT OVERVIEW

Photo 1: Local stakeholders tour a Drop-in Center. Photo credit: PACTE-VIH (2015).

To address critical gaps in key population programming in West Africa, USAID paired with FHI 360 to develop PACTE-VIH, with the goal of creating "a replicable project that reaches key populations with HIV and STI testing while reducing stigma by creating an enabling environment for MSM and FSWs in Burkina Faso and Togo." PACTE-VIH is a five-year agreement with two sub-partners in Togo, and 10 sub-partners in Burkina Faso. Project objectives are to:

1. Develop a scalable, replicable model that can be adapted in the region for the provision of essential and comprehensive prevention and support services for key populations
2. Create an enabling environment for optimized HIV prevention among key populations
3. Provide technical assistance to national and local organizations
4. Disseminate promising practices throughout the region

These key objectives were led by four guiding principles:

1. Use evidence-based and cost-effective approaches to maximize effective and efficient responses
2. Build capacity for long-term sustainability
3. Promote gender awareness and mitigate the impact of gender-based discrimination and violence
4. Foster partnership and collaboration

Led by these objectives and guiding principles, PACTE-VIH implementation partners (IPs) developed a package of services using four key strategies: peer education (PEd), a clinic services strategy, drop-in centers (DIC), and support for an enabling environment. Although Burkina Faso and Togo vary in many ways, the overall structure, activities, and key components of this program were similar between the two project sites, suggesting an approach that can and should be replicated throughout the region.

? WHY A REPLICATION TOOLKIT?

Although some great ideas spread fast, others take years to be put into practice; analysts suggest that the average time between health discovery and change is 17 years.[3] In order to decrease this gap, governments, health care providers, advocates and civil society must implement deliberate, planned, and managed efforts to establish and sustain new and effective practices. Although the model for replication can vary, any replication model should consider five basic components: intervention, resource team, user group, external environment, and the strategy or plan.

In response to the clear need in the West Africa region to expand projects that have effectively reached key populations with HIV programming (and the promising results of the PACTE-VIH Project, now in Year 4 of implementation), USAID and PACTE-VIH developed this replication toolkit to provide tools, lessons learned, and steps for project implementation in a user-friendly format.

What is the goal of the toolkit?

The goal of this toolkit is to increase access to and the quality of prevention, care, and treatment services for key populations by facilitating the replication of the PACTE-VIH model.

What are the toolkit's objectives?

This toolkit has three objectives:

1. Describe the components of the PACTE-VIH model and discuss how each component was developed and implemented
2. Share key project resources: training curricula, service delivery protocols, and materials for information, education, and communication (IEC), and behavior change communication (BCC)
3. Provide guidance and recommendations for replication of the model

How was the toolkit created?

The PACTE-VIH replication toolkit was created in collaboration with FHI 360 country partners in Ghana who managed the project throughout its duration. In 2015, a USAID funded mid-term evaluation was conducted by local sub-partners who performed qualitative evaluations and quantitative data analyses to assess the progress of the project. Project partners also hired a local firm to conduct in-depth interviews with implementation partners (IPs), DIC managers, and sub-partner clinic staff members. After all essential documentation was collected, project partners collaborated with FHI 360 headquarters technical staff to develop this replication toolkit using the data and tools collected from the evaluation, interviews, and project documentation (including annual reports, work plans, and tools developed or used by IPs).

What is in the toolkit?

This replication toolkit includes four sections, which describe the core components of the PACTE-VIH project (PEd strategy, clinical services strategy, DIC strategy, and enabling environment strategy), and how these components can be adapted and replicated. Each section includes: 1) a snapshot table summarizing key content in that section of the toolkit; 2) a summary of major strategy activities; 3) stakeholders involved in the strategy; 4) preparatory steps; 5) a detailed description of implementation steps; 6) challenges and facilitating factors to planning and implementing the strategy; and 7) considerations for strategy replication. In addition, each section includes real examples or success stories of strategy implementation from projects in Burkina Faso, Togo, or both. Finally, toolkit users are directed to tools that were used in the PACTE-VIH project (found in the toolkit annexes) that can be adapted for project replication.

Who is the target audience for this toolkit?

This toolkit will be useful for the implementation of key population programs among those who plan to adopt or adapt the PACTE-VIH model to provide essential and comprehensive prevention and support services for key populations in mixed epidemic environments that have high levels of stigma and discrimination. Potential users include nongovernmental organizations, government representatives, and donors who fund key population programs.

Organizations or coalitions interested in replicating the PACTE-VIH model should consider several overarching aspects of the project in addition to the five key strategies detailed in the rest of the toolkit.

KEY CONSIDERATIONS FOR REPLICATION OF THE PACTE-VIH PROJECT

Government buy-in

Government buy-in — beginning with project planning and continuing throughout the life of the project — was a critical component of the PACTE-VIH. Implementing partners in Burkina Faso and Togo enlisted two government "champions" — a leader from the National Aids Control Committee (NACC) and a leader from The National Aids Control Program of the Ministry of Health — to contribute during project planning and to provide support during project implementation, including advocacy efforts for policy change. The "champion" and other government stakeholders were also essential in adapting the national strategy for HIV programming and STI prevention for key populations in Togo. In Burkina Faso, the NACC set up a steering committee that has helped to define the strategic direction of the project and facilitate its implementation on the ground.

Obtaining cooperation from, and coordinating with, government officials may be challenging and time consuming for future implementers, particularly for processes as arduous as advocating for policies to support HIV programming for key populations. However, it is nearly impossible for projects to develop new policies, change existing policies, or implement training or workshops in government-run clinics without buy-in from government stakeholders.

HIV cascade

The HIV cascade framework "is a system to monitor the number of individuals living with HIV who are actually receiving medical care and the treatment they need." [4] The framework is aligned with the United Nations 90–90–90 objective: "By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression."[5] The cascade approach for reaching key populations, as illustrated in Figure 1, was developed by the LINKAGES Project (a globally implemented USAID and PEPFAR funded project for HIV prevention among key populations); PACTE-VIH used a similar approach to coordinate project partners with IPs to develop strategic programs that prioritized the greatest needs in the provision of HIV prevention, diagnosis, care, and treatment services to key populations.

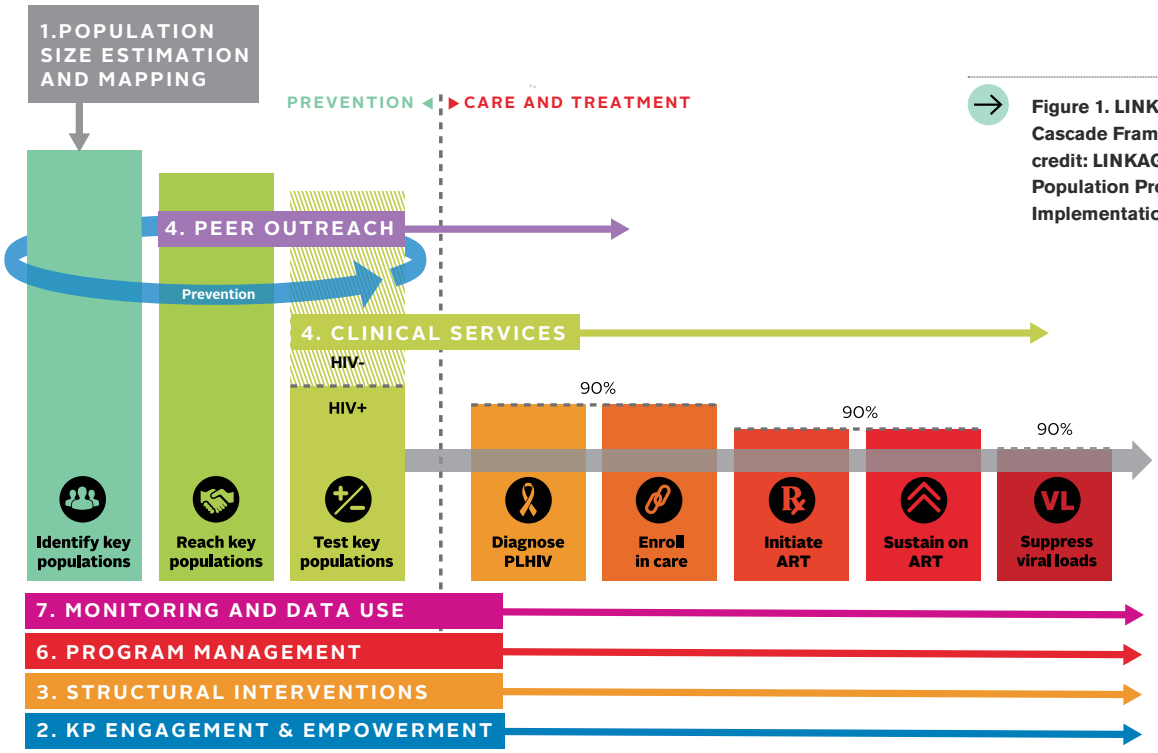


Figure 1. LINKAGES HIV Cascade Framework. Image credit: LINKAGES Key Population Program Implementation Guide (2016).

The HIV cascade framework can be used by both IPs and field support staff members (such as health care workers, PEd mangers, and DIC mangers) as a decision-making tool to help determine successes and gaps in performance. By routinely collecting data and applying it to the cascade, project staff members can gain a quick snapshot of the most strategic places for intervention to maximize the number of key population members who are reached.

Advocacy

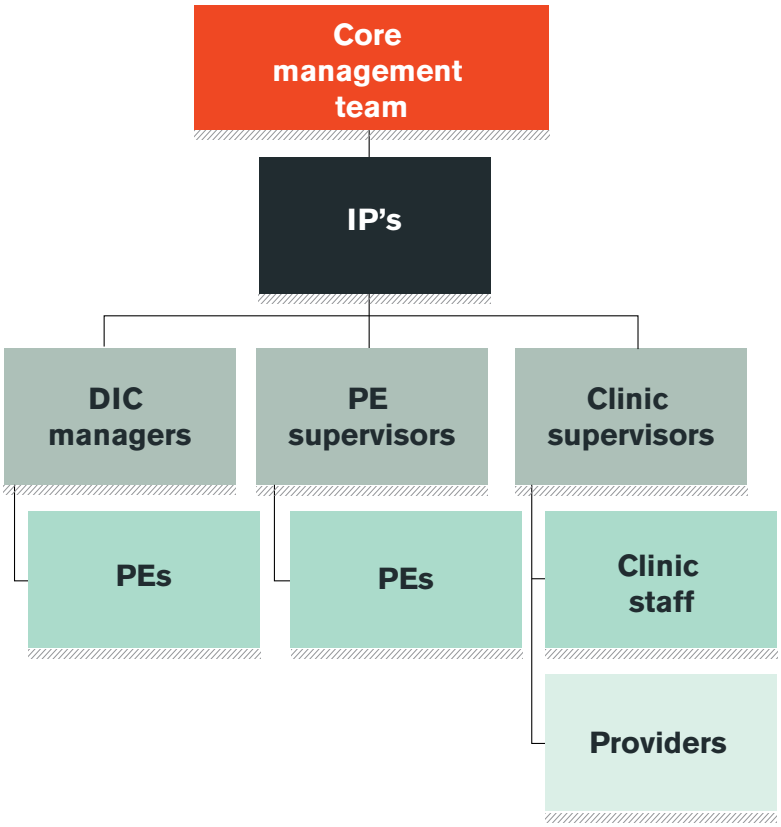
To advocate for HIV prevention and care services, the PACTE-VIH project collaborated with influential individuals and organizations. These people assisted with strategy development and implementation, invested resources in the project, helped to sustain specific program activities, and worked to prevent other organizations from hampering the implementation of the project's activities. For example, advocacy work by the PACTE-VIH projects in Burkina Faso and Togo gained essential support from the NACC, Ministry of Health (MOH) officials, and religious leaders — which allowed the project to implement activities for key populations within a context marked by stigma and discrimination.

Project management

The PACTE-VIH projects in Burkina Faso and Togo have similar management structures. Both country projects are overseen by a core management team that utilized existing data and resources to plan the project, found new resources and partnerships (including liaising with government stakeholders prior to project implementation), designated IPs, and maintained progress throughout the project by sustaining the monitoring and evaluation (M&E) processes and by managing personnel. Implementing partners are managed by the

core management team and were the primary implementers in each project region. The activities managed by IPs are diverse, including the designation of peer educators, clinic services, management of drop-in centers, and M&E. Individual managers of drop-in centers, peer educators, case managers, and clinic supervisors were managed by IPs and were in charge of the daily activities included in each PACTE-VIH strategy.

Figure 2. The PACTE-VIH management structure.



Projects that replicate PACTE-VIH may not have the same management structure, but the example from Burkina Faso and Togo can serve as model that can be adapted as necessary.

Data collection for early project planning

Data-collection efforts from several different organizations, including local NGOs and facilities already offering key population services in Burkina Faso and Togo, were conducted prior to project planning or implementation. Through this process, some of these organizations and facilities ultimately became IPs for the project. In this toolkit, "implementing partners" refers to stakeholders who are designated by the project as key partners in the project planning, implementation, and M&E processes. Implementing partners may vary by region of project replication — examples of IPs might include: NGOs invested in the project, project managers, or individuals designated specifically for providing inputs to the project.

Photo 2: Project staff receive training on monitoring and evaluation processes. PACTE-VIH (2015).

Prior to project implementation, a landscape analysis was conducted in Burkina Faso and Togo (as part of previous projects) to evaluate the overall environment for key populations and its readiness for HIV programming. Similar to a situational analysis, the landscape analysis consisted of a desk review to analyze the legal, political, and social environments in each country, as well as the overall prevalence and size estimations from data previously collected and published by USAID.

To determine the political landscape and to develop a strategy for creating an enabling environment, the project collaborated with ACI (a local partner) to conduct a needs assessment, which included a literature review and focus group workshops with key stakeholders and members of key populations. Site mapping was conducted in collaboration with the Global Fund to identify key geographical areas to target for the implementation of the PACTE-VIH project because of critical gaps in coverage of clinics and services, and where HIV prevalence was high.

The IPs also conducted qualitative interviews to assess clinic capacity, and performed an analysis of clinics using evaluation tools from FHI 360. The project also used the results of other USAID partners to conduct programmatic mapping. This helped us to determine where key populations congregated and where to provide services (including types of services and operational dynamics). These activities helped IPs to identify the needs in each region, which key stakeholders to involve, and how to form strategic solutions to address those needs. After the hotspot sites and clinic sites were determined, another partner conducted a baseline analysis to determine the specific needs of key populations and the gaps to be addressed by the project. A report was developed from these analyses to summarize opportunities, challenges, and priorities for the PACTE-VIH project.

I. PEER EDUCATION STRATEGY

The peer education (PEd) strategy engages FSWs and MSM to work with members of their respective key population communities to provide information and resources for behavior change, distribute commodities (such as condoms and lubricants), and to provide referrals for testing and treatment services.

Peer Education Strategy – A Snapshot

Section	Details
1. Activities in the PEd strategy	• Strategic Behavior Change Communication • Commodity distribution • Referrals
2. Stakeholders involved in supporting and implementing the PEd strategy	• IPs • Members of key populations • Community associations • Clinics (sub-partners and customized services) and facility-based staff members • Government stakeholders
3. Preparatory steps for the PEd strategy	• Recruitment • Development of the training manual • Training • Monitoring and evaluation
4. Implementing the PEd strategy: detailed description	• Strategic Behavior Change Communication • Commodity distribution • Referral services • Other services provided by PEs
5. Challenges and facilitating factors in the PEd strategy	• Challenges: funding, stock-outs, stigma against MSM, stigma against FSW • Facilitating factors: utilization of existing resources
6. Key considerations for replicating the PEd strategy	• Stakeholder buy-in • Location of services • Recruitment • Training • Commodity distribution • Referrals • Utilize existing resources • Monitoring and evaluation

1. Activities in the peer education strategy

The PEd strategy is comprised of three types of activities: strategic behavior change communication (SBCC) activities (which include community outreach, group and one-on-one sensitization sessions, and in-home/hospital visits), commodity distribution (distribution of condoms and lubricants), and referrals (to clinics or DICs). Through these activities, PEs are able to reach members of their own key populations, increase their knowledge of HIV, and help them to reduce risky behavior and HIV transmission.

2. Stakeholders involved in supporting and implementing the peer education strategy

Stakeholders include members of key populations, IPs, sub-partners, community associations, local clinics, and government employees. The stakeholders who are chosen, and their level of involvement, may vary per country or region. The involvement of stakeholders is essential for ensuring that the PEd strategy receives the necessary guidance and support for project preparation and successful implementation.

Implementing partners

Recall that "implementing partner" is a blanket term for any partner who is designated as key to the project's implementation. In Burkina Faso and Togo, IPs are awardees of sub-grants who served as catalysts to engage local clinics as sub-partners or to offer customized services — called "services adapté clinics" in Burkina Faso and Togo — which work with peer educators (PEs). These efforts included the recruitment and hiring of all PE staff members and contributing to the development of a training manual to guide PEs in standards and processes for all outreach, commodity distribution, and referral activities. Implementing partners can also work with sub-partner clinics and customized service clinics to engage PEs and case managers in clinic reception, and develop a strategy for DICs to engage PEs in activities for outreach and commodity distribution.

Members of key populations who serve as peer educators

Implementing partners can recruit PEs in the communities where outreach activities will be conducted. Local PEs are more likely to be familiar with these regions, which improves the prospects of making connections to key populations and other community leaders. The PEs should also be members of the key populations they serve.

(For details on the selection criteria, see the section on PE recruitment.)

Clinic services and facility-based staff

Clinical services were implemented by PACTE-VIH in three different forms: sub-partner clinics, customized service clinics, and mobile clinics. Sub-partner clinics worked with IPs and provided exclusive services to key populations within NGO facilities or community-center facilities. These locations provided the ideal environment for key populations to receive services, and received the highest priority as referral locations for the PACTE-VIH project. Customized services were provided through public health facilities (that served the general public) and were adapted to meet the needs of key populations. These locations signed a memorandum of understanding with the PACTE-VIH project. Mobile clinic services were provided through a mobile unit with two cabins: one for screening and one for health care services. A designated focal-point person at each clinic worked with PEs to monitor referrals from PE outreach. Facility-based staff members also collaborated with IPs and PEs who assisted with sensitivity training for clinic staff.

The IPs can establish a network of clinics as potential sub-partner clinics and customized service clinics before project implementation by mapping and assessing the available clinics to determine which have the capacity and willingness to offer services to key populations.

(For more information, see the Clinic Services Strategy section.)

Government stakeholders

Government stakeholders are essential to all aspects of the project. For the PEd strategy, government stakeholders can help to develop supportive policy and legislation, ensure the safety and security of PEs before they go into the field, and prevent stock-outs of commodities that are essential for PE outreach activities.

3. Preparing for the peer education strategy

The following steps will help you to prepare for the PEd strategy:

- Recruit PEs
- Develop a training manual
- Train PEs
- Monitoring and evaluation. Effective M&E should be employed during every stage of the project, (including the preparation and planning phases); it helps to ensure that ample time and resources are allotted for the activities.

Recruitment and training

Recruit peer educators

The PEs should be recruited during the first year of the project (see the annex for a *project timeline sample*). In the PACTE-VIH project, IPs were responsible for recruiting PEs and defined the selection criteria for PEs in order to recruit only those candidates who were ideal for the position. For example, the projects in Burkina Faso and Togo required that all PEs were capable of reading and writing, willing to participate in project activities, members of the target key populations (MSM or FSW), honest, welcoming, able to understand privacy, well established in relationships within his or her community, 18 years or older, understood communication techniques and group facilitation, and was knowledgeable about transmission and prevention of HIV.

It may be valuable to recruit PEs who are members of specific groups within their respective key population (such as students who are MSM or FSWs who work in particular environments). These PEs may help the project to reach individuals who may not want to be identified as members of a key population. For example, in Burkina Faso, certain PEs who also worked as businessmen were recruited to reach members of that group. Many MSM in Burkina Faso do not want to risk exposure as MSM, but they felt safe disclosing it to a member of their own subpopulation group, and were therefore more likely to go to a clinic to receive additional services.

The IPs, or those in charge of recruiting PEs, should consider using the "social network strategy" (SNS) method as a PE technique in regions where stigma and discrimination are high (which makes it difficult to locate qualified members of key populations). Through SNS, advertising is used to recruit a small number of PEs, who then refer other PEs for recruitment: "I have a friend who knows someone who would be perfect…." An SNS can similarly work as a successful outreach technique in other components of the project.

During project start-up, IPs should consider whether key populations in the implementation regions are highly transient (due to the nature of their work or because of high levels of stigma and discrimination). If so, the IPs may need to recruit (and train) more PEs than would otherwise be required to meet all PEd strategy activity goals. For example, because of the highly transient nature of FSWs in Burkina Faso, PACTE-VIH IPs recruited more than twice as many FSWs than were initially needed to maintain adequate numbers of PE staff members through the life of the project.

Develop the training manual

For efficiency of both budget and time, projects should consider using existing PE training materials (including a training manual). However, it is essential that the materials are adapted to accommodate the laws, customs, and norms of the country or region where the project will be implemented. Members of key populations, those experienced in implementing key population services in the region for adaption, and experts on stakeholder groups (e.g., a government consultant or provider) should be involved in the adaptation process.

(See the annex for an example of the PE training manual used by the Burkina Faso and Togo PACTE-VIH projects. The manual was adapted from a manual used for a similar project in Cote d'Ivoire.)

Train PEs

The PEs should be trained on all topics and issues pertinent to the PEd strategy for their region using the adapted training manual. Important training topics include:

- How to make contact with key populations
- Motivating key populations to get tested
- Conducting group sessions
- Promoting consistent and correct condom use
- Promoting correct and consistent use of appropriate lubricants
- Promoting STI testing
- Conducting STI consultations and screening
- Referring key populations to appropriate resources
- Conducting M&E activities as needed, including client tracking and completion of activity sheets
- Gender issues

Depending on their previous experience in PEd work, PEs may also require training in violence against key populations, training on how to effectively conduct outreach, and general standards of conduct (such as active listening, avoiding discussions of their own personal issues, and remaining compassionate). The IPs may take a collaborative approach by receiving feedback directly from PEs about what does and does not work for PEd strategy activities.

(See the annex for the PE training manual and for a list of indicators to use for testing the effectiveness of training.)

Photo 3: PEs distribute condoms to female sex workers. Photo Credit: PACTE-VIH (2015).

Materials needed for recruiting and training peer educators

- A training manual, which can be adapted from an existing training manual from a similar project using PEs for key population HIV programming (see annex)
- Additional training materials, including a wooden phallus, male and female condoms, a logbook for PEs to use, pens or pencils, sample referral coupons, and sample data-collection sheets for PEs to practice making entries
- Documentation on the continuum of care, which provides policies on prevention and comprehensive care on HIV for key populations in the given country
- A monthly schedule (PE outreach hours, DIC hours, scheduled PE check-ins, and outreach themes)
- Pre-test and post-test evaluations

Monitoring and Evaluation

Map hotspots

Hotspots can be located through a landscape analysis (described in the introduction section of this toolkit) and through programmatic mapping. The evaluation of current hotspots and identification of new hotspots for development can be aided by PEs who develop their own maps during outreach activities. A matrix of information should include the following: city name, municipality name, region and sub-region names, site name, type of site, nearby landmarks, information about the person referred, and the clinic designated by the referral. For the latter, PEs can fill out a mapping matrix when they provide sensitization or outreach services. This mapping process helps IPs and core management partners determine whether outreach activities are reaching high numbers of key population members in a particular area, and it provides an opportunity to re-evaluate outreach at new locations if the number of key population individuals decreases in the current location. The site supervisor is then responsible for maintaining mapping of these regions, and determining designated hotspots.

(*See the annex for an example of the mapping matrix*)

Unique identifier codes

A unique identifier code (UIC) system can help projects monitor patient data in order to evaluate project effectiveness, and it also ensures the confidentiality of patient data. Confidentiality is of particular concern to key populations and PLWH, so it is very important to create a system that prevents test results or other confidential health data from being linked to the individuals who visit a clinic for testing. See the box (below) for an example of how the UIC system was used in the PACTE-VIH projects in Burkina Faso and Togo.

Using a UIC system

The PACTE-VIH projects in Burkina Faso and Togo developed a UIC for each key population member who was tested to ensure that the information collected on that patient remained confidential. The UICs are composed of seven alphanumeric characters, recorded in the following order: sex (M or F), the last two digits of year of birth, the first letter of the last name, the first letter of the first name, and the first two letters of the first name of the client's mother. For example, a male patient, named John Smith, was born in 1976, and his mother's name is Mary; his UIC would be: M76SJMA.

Each UIC was recorded on a referral coupon by PEs, and verified by the clinic's point person to ensure accuracy and to determine whether the client had previously visited the clinic. If the client had never been to the clinic, and the referral was his or her entry point to clinical services, the client was assigned a new UIC at the time of referral. If a client did not have a referral coupon when they visited the clinic, a UIC was assigned or verified by the clinic's point person and entered into the client database.

Supervisory check-ins for peer educators

In the PACTE-VIH project, the supervisors of PEs were IPs or managers of DICs. Supervisors should schedule regular (monthly or bi-monthly) check-ins with PEs as part of project monitoring and for continuous capacity building of PEs. During check-ins, the supervisor should review data-collection tools to determine whether the PE is filling them out completely and accurately. The supervisor should also check that the PE has an adequate supply of outreach tools (e.g., referral coupons, flip charts). Supervisors also support PE in the development of their monthly activity plans, identifying topics to be discussed by the PE during the month, and supervising at least one activity of each PE every month. Supervisors should also discuss overall project implementation with the PE, help to identify challenges and propose solutions, and discuss opportunities to expand the referral network, the condom and lubricant distribution points, and the hotspot locations.

Key indicators for the peer education strategy

Projects will need to determine or develop definitions for each indicator and adapt them from global guidance documents. The PACTE-VIH project used global definitions (from PEPFAR), and adapted them to their specific program context based on feasibility.

(See the annex for additional guidance from the PACTE-VIH Project Management Plan.)

Indicator:

- Number of male condoms, female condoms, and lubricants distributed to FSWs and MSMs
- Number of key population members reached with individual or small-group interventions that were based on evidence or met the minimum standards
- Number of people who were sensitized on the proper disposal of condoms and lubricants
- Number of persons referred for a service
- Number of persons referred for a service who accessed the service
- Number of PEs who received regular and supportive supervision and mentoring

4. Implementing the peer education strategy: detailed description

After preparatory activities are completed, IPs should move to the implementation phase of the PEd strategy. Here we provide a detailed description of each activity in the PEd strategy, according to these four categories:

- SBCC, including community outreach, group and one-on-one sensitization sessions, and visits to homes and hospitals
- Commodity distribution
- Referrals, through a coupon system, to a service delivery point
- Other services

Strategic behavior change communication (SBCC)

Community outreach

Community outreach services can be conducted when PEs visit "hotspots" — specified locations where FSWs or MSM regularly congregate. For FSWs, these include "sex entertainment establishments," "snacks" (small bars where food is offered), bars, brothels, hotels. For MSM, hotspots include designated safe locations. Hotspots may be identified through mapping (which is a continuous process involving revision of hotspot maps, according to information provided by PEs) or through a landscape analysis.

(See the annex for an example of the mapping matrix)

To commute to hotspots, PEs may use various forms of transportation, including bicycles or cars, and a small portion of the project budget should be allocated for reimbursing PEs transportation costs when applicable. Once PEs reach the hotspot, they should seek out members of their respective key population and provide one-on-one or group sensitization (more on this topic in the following section).

Safety of PEs may be of particular concern during visits to hotspots, especially for PEs who conduct community outreach for MSM. Unsafe environments (because of stigma and discrimination) may force PEs to conduct SBCC activities in less-public locations, such as in the homes of MSM or in DICs.

Group and one-on-one sensitization sessions

Group and one-on-one sensitization sessions can occur at clinics, DICs, community outreach locations, "hotspots," and during home visits. Group sensitization at DICs may also occur during occasional "parties," which can include food or music to provide a welcoming environment for MSMs.

Materials needed for all SBCC activities

- Logbook for documentation of PE sessions
- Training manual for PEs
- Flipcharts that visually depict themes (e.g., proper use of a condom)
- Flyers
- Pocket-sized information sheets and posters that address key health issues (proper condom use, risk reduction, HIV and STI symptoms, gender-based violence and gender equity, self-esteem, and management of self-stigma)
- Transportation for PEs (ideally, provide a reimbursement for transportation)

During these sensitization sessions, PEs deliver SBCC information based on a theme chosen for that week. Discussion themes are determined by IPs before project implementation, and PE supervisors work with PEs to designate a theme on a monthly basis, and to ensure that PEs have the correct "awareness activities sheet" information for that particular theme.

(See the annex for an example of the awareness activities sheet)

Although themes can be elicited from the PE training manual, they should be adapted to take cultural context and norms into account. Sensitization themes might include the proper condom use, general HIV education, proper disposal of biomedical waste, and how to negotiate condom use.

(See the annex for the PE training manual, which includes additional details and resources for each theme, including demonstration pictures.)

Example of a sensitization session

For one sensitization session, PEs were responsible for providing information about proper condom use, STIs, HIV, screening key populations, and monitoring key-population activities through tracking sheets. They also gave demonstrations on the correct use of a male condom and the proper use of lubricant. The PEs started the session by giving a general informative overview, followed by an eight-step demonstration (using a phallus) on how to properly put on, use, and dispose of a condom. For FSWs, group and one-on-one sensitization sessions also occurred at their place of employment. The PEs worked with the managers in places of employment for FSWs to gain their consent for conducting sensitization sessions with their employees on the premises of their bars, brothels, or "snacks." This method benefitted the outreach goals of the project by increasing the number of people reached with sensitization information, and by increasing the distribution of condoms and lubricants. Using this method, PEs were able to establish a rapport with FSWs and their managers, which also increased the likelihood that FSWs would visit the clinics if they were given referrals.

Photo 4: A PE conducts a group chat session with female sex workers
Photo Credit: PACTE-VIH (2015).

Home and hospital visits

One option for key population members who are already diagnosed with HIV — but cannot visit a clinic or DIC because of an illness — is for PEs to visit their homes to provide sensitization services, condoms, or referrals to be used when the client is strong enough to visit a clinic for care services. In the Togo and Burkina Faso PACTE-VIH projects, home visits to MSM provided opportunities for group gatherings (called "grains") or one-on-one sensitization sessions when the MSM did not feel it was safe to gather in public because of stigma and discrimination in their community.

Hospital visits can also occur on an as-needed basis if an individual who is living with HIV is unable to visit a DIC or clinic because of an illness.

Commodity distribution

Condoms and lubricants effectively prevent sexual transmission of HIV, particularly among people who have multiple sex partners. The distribution of condoms and lubricants is an essential part of the PACTE-VIH project; it is an integral part of assuring the effectiveness of the PEd strategy and a major part of the continuum of care strategy.

The IPs should develop a logistical supply chain to prevent stock-outs. This may include working with country policies and procedures for condom procurement. For example, in the PACTE-VIH projects in Burkina Faso and Togo, condoms were kept at the national central stock, where a quantification process occurred during routine and quarterly meetings with the government and other projects (including USAID partners). Once IPs obtained condoms from the national stock, they distributed these condoms to DICs and clinics. (The number of condoms distributed to each site was based on data that were collected during monitoring activities).

Male and female condoms and lubricants can be distributed at a variety of venues, including sensitization sessions, hospital visits, home visits, and group sessions at DICs. The FSWs can be reached at the brothels, "snacks," and bars. And the MSM can be reached at parties held in DICs or bars (where sensitization sessions also occur). The PEs can distribute large amounts of these items during community outreach activities to encourage key population members to follow through with their referrals. Prior to distribution, PEs should document the number of commodities they received. After the outreach is completed, the PEs should document how many commodities were distributed. Commodity distribution should be monitored through the use of tracking sheets that are distributed to the PEs during training (and restocked as needed). The tracking sheets should be reviewed periodically for accuracy by the PE supervisor.

Condoms can be offered for free or for a fee, depending on the project's strategy and the country's laws. Understanding the national laws on condom distribution and sales is an essential step prior to implementing the program. The PACTE-VIH project used both approaches and had to adjust their strategy to accommodate the country's laws. In Burkina Faso, all commodities were distributed for free. However, in Togo, the NACC does not recommend free condom distribution until the individual receives counseling, sensitization, or testing services.

Materials needed for commodity distribution

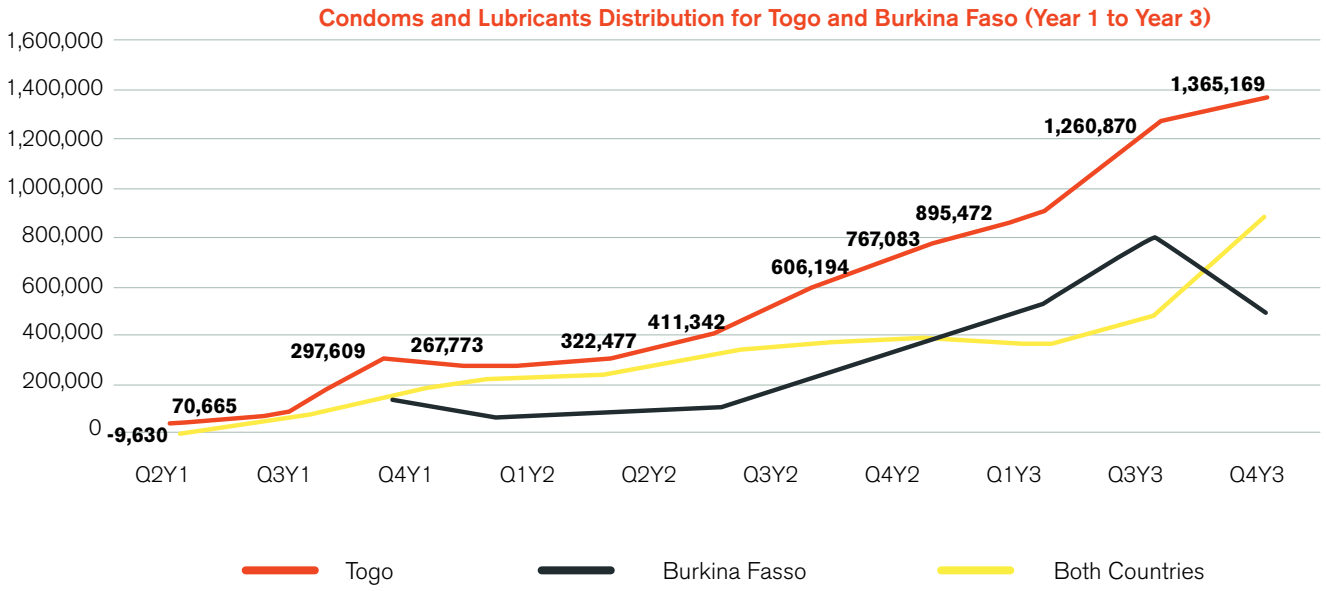
- Tracking sheets to monitor the number of condoms distributed
- Male and female condoms
- Lubricants
- Condoms

For the sale of condoms, the IPs hired sales people who participated in a brief training on key population sensitization and condom distribution that was facilitated by the IPs. Sales occurred at small shops and boutiques that sold other goods, usually located near hotspots. The sales people could purchase condoms from the project for a slight discount, and then sell them for a small profit. Condom prices are based on national standards and do not compete with the prices of other projects selling condoms in the region.

Projects may choose to collaborate with other social marketing organizations that have worked on condom campaigns, or they may choose to use popular brands of condoms to encourage sales. For example, in Togo, the NACC does not encourage the sale of generic condoms and the social marketing program (PROMACO) has the exclusive right to distribute condoms at reduce costs (through social marketing) in the country.

During the course of the PACTE-VIH projects in Burkina Faso and Togo, commodity distribution greatly increased from Year 1 to Year 3. The chart (below) depicts the drastic increase of condoms distributed during that three-year timeline.

Figure 3. Condom and lubricant distribution.



Referral services

The PEs used a coupon system to refer key population members during outreach visits, and at DICs. The key population members can be referred to sub-partner clinics, customized service clinics, or DICs. This system is particularly effective for reaching key population members who would otherwise not have access to facility and community-based services to address their multidimensional needs. For monitoring purposes, PEs were given sheets with three identical coupons: one copy was to be retained by the PE, another was distributed to the PE supervisor, and the third copy was given to the key population member. The information on the coupons include: the key population member's name, assigned UIC, the referral type(s), and the service delivery point (a customized service clinic or sub-partner clinic). When a key population member reported to the clinic, he or she handed the coupon to a trained focal-point person who directed the individual to the referred service. Providers then marked their name, the date, and the service(s) the individual received on the referral form. Referral sheets are stored at each service location, where they are collected monthly by the PE supervisors. The supervisors compared the three referral slips for each key population member for accuracy, recorded the number of individuals who received services, and which services were received. The key population members who visited the clinics without coupons were assigned UICs when they checked in to the clinic.

Materials needed for referral services

- Coupon books
- Logbooks for tracking coupon distribution
- Condoms and lubricants

Other services provided by PEs

Assistance with legal issues

Some PEs may be trained to provide financial or legal services to assist key populations in cases of arrest or legal harassment. The PEs can leverage their rapport with key populations and their external communities to advocate for those who need assistance. However, it may be difficult to find PEs who can provide financial or legal service to key populations. Future programs may consider forming partnerships with other organizations that provide these services. For example, the Togo project partnered with a legal counsel NGO that provided legal services to key populations at the DIC once a week. PACTE-VIH also created an Mfriends group (experts including doctors and lawyers) for referrals. The Mfriends group is a USAID model previously implemented in Ghana and India and adapted by PACTE-VIH to develop an "integrated community network program to detect and prevent human rights abuses against key populations and assist victims of abuse." This network consists of responsible, respected community members who are trained volunteers, members of key populations, and who are connected with local organizations that can respond immediately to human rights abuses against key population members.

5. Challenges and facilitating factors for the peer education strategy

Challenges

The IPs may encounter a number of challenges (below) during the planning and implementation of the PEd strategy; these issues should be considered in the project's work plan and budget to prevent unnecessary roadblocks.

Funding

Transportation for PEs may become a challenge if is not written into the budget. For example, in Burkina Faso and Togo, some PEs had difficulties visiting outreach sites and hotspots because they could not afford transportation. Others expressed frustration that they had to pay for their own transportation or were not adequately compensated.

The budget must account for the staff's salaries (including PE managers) at a level that is considered to be adequate by the employees. Although PACTE-VIH partners in Burkina Faso and Togo did advocate for higher staff salaries, the project work plan did not have an adequate budget to support their request.

During project planning, an understanding of the expectations of key populations is essential in order to provide supplies and funding when necessary. For example, in Burkina Faso and Togo, some FSWs did not participate in sensitization sessions because snacks were not provided. Also, some managers of brothels or bars expected compensation or bribes for allowing their employees to participate in strategy services. Because bribes are not permitted, it was initially difficult to gain participation from these managers and their employees. The provision of snacks and drinks during outreach, parties, or group chats proved to be a successful strategy; future project should consider a budget for these items.

Stock-outs

Stock-outs of commodities — including condoms, lubricants, STI testing kits, and HIV-testing supplies — can have a negative impact on the overall effectiveness of PE outreach activities. During the early stages of the projects in Burkina Faso and Togo, stock-outs would occur when the government did not participate and the logistical supply chain was interrupted.

Stigma against MSM

Stigma against MSM in the community and among medical providers can be a challenge for referring MSM to clinics where they will receive stigma-free, safe, and comprehensive services. Stigma can compromise safety, cause MSM to go into hiding (where PEs cannot reach them with outreach services), prevent the establishment of hotspots, and increase the likelihood of loss to follow-up.

Stigma may also be a challenge in regions where sex work or homosexuality are illegal, so FSWs or MSM can be accused of participating in these illegal acts if they are caught with large amounts of condoms. For example, key population members in Burkina Faso and Togo were reluctant to receive 10 or more condoms during sensitization sessions because they feared incrimination if the police should stop them with so many condoms on hand.

In Burkina Faso, MSM employed a strategy of meeting in small groups or in homes instead of public hotspots for outreach services. Sensitivity training was conducted for providers and clinic staff members to eliminate negative attitudes within the clinic.

Stigma against FSWs

Stigma can marginalize FSWs, forcing them to use dangerous locations for “hanging out” or working. Visits to these hotspot locations can increase violent acts against PEs and FSWs, so safety training is essential for PEs. Also, if PEs do not feel that a location is safe, they should avoid it and find a new location for outreach.

Because of stigma and discrimination, FSWs can be highly mobile, which may cause loss to follow-up for referrals and clinic services, and a loss of trained PEs.

To address this issue, the IPs in Burkina Faso and Togo trained multiple FSWs to be PEs so that outreach efforts were not decreased if the PEs relocated.

Facilitating factors

The following considerations helped IPs successfully implement PEd strategy in Burkina Faso and Togo, and can provide guidance to future project implementers on how to leverage key strategies for successful implementation.

Utilization of existing resources

The PEs who are members of key populations and already trained in providing peer education (perhaps from working in past projects in the region) should be recruited for future projects. Because these PEs already have much of the necessary experience, they can begin working as PEs much more quickly and with less training. These PEs may also have an established rapport within their communities, which can increase both outreach capacity and the number of referrals.

The IPs should map existing structures (in the private and public sectors) that have the capacity to provide clinical services to key populations if given appropriate technical and sensitivity trainings. By utilizing existing clinics for PE referral locations, projects can reduce costs and key populations will receive referrals to receive stigma-free comprehensive care beginning at project start-up.

Adapting existing tools from previous projects is an effective way to lower project costs and ensure that the PEd strategy is based on proven approaches. For example, the PEd training manual was originally implemented in Cote d'Ivoire, and was adapted according to the regional norms, laws, and customs in Burkina Faso and Togo. Using existing tools can also prevent projects from spending unnecessary time and resources on developing new tools and materials.

6. Considerations for replicating the peer education strategy

These eight items (see box below) are absolutely critical for ensuring successful implementation of the PEd strategy. The list includes essential factors to anticipate and overcome, and potential adaptations to adopt when replicating the PEd strategy.

1. Stakeholder buy-in
2. Location of services
3. Recruitment
4. Training
5. Commodity distribution
6. Referrals
7. Utilize existing resources
8. Monitoring and evaluation

Stakeholder buy-in

At the planning stage, ensure that all key stakeholders (including PEs) contribute to the project's planning and development. Key members of MSM and FSW communities should be engaged in developing the strategic framework of the project, and the project's management should ensure that all relevant feedback from key population stakeholders is integrated into project strategies.

Location of services

Make efforts to provide clinic services around hotspots or other locations where many key populations congregate. This will provide easy access to services when key population members are referred by PEs conducting outreach. These locations can be determined by conducting a landscape analysis, including the mapping of clinic locations. Projects can also plan to implement a system of mobile clinics to increase access for key populations and fill gaps where stand-alone clinics are not available. The PEs can leverage these mobile locations to reach key population members who otherwise may not visit a stand-alone clinic, even if they receive referrals.

For outreach services, projects should consider helping PEs to strategically plan key population outreach in locations that have a greater reach. For example, managers of FSWs may prefer that group sensitization is conducted during staff meetings in the places where FSWs work; because all staff members will be present, PEs can reach a larger audience. Outreach services provided at public locations (such as "snacks" where FSWs work) may also engage passersby or patrons at businesses (including male clients of FSWs) in sensitization sessions. It is always imperative to consider the safety of PEs in all outreach locations.

Recruitment

Recruit PEs who are members of key populations and reputable in the community or region of project implementation. The PEs can be recruited using SNS, where one or two PEs refer friends or past colleagues, and, in turn, those people refer someone, and the chain continues. Projects should identify criteria for PEs to ensure they will be able to reach the target key populations, and that they are able to perform the duties associated with the job.

Training

The training and supervision of PEs should be continuous. In addition to initial training, PEs should also be supported by their supervisors while receiving practical field training experience. Supervisors are responsible for ensuring that PEs are familiar with the content of the SBCC materials and demonstrate their ability to use them effectively. The project can be made exponentially more effective by allowing PEs to provide suggestions and feedback on how these materials and procedures can be improved. Supervisors should also conduct regular check-ins with PEs, and annual refresher courses on materials, outreach, and M&E processes. To ensure staff retention, limit the time between the recruitment and training of PEs. To ensure knowledge retention, limit the time between training and the beginning of working.

Commodity distribution

Be sure you have a solid logistical plan and supply chain to ensure a constant stock of condoms, lubricants, and testing supplies for PEs, clinics, and DICs.

Recruit a government "champion" to advocate for government buy-in to the project, particularly if IPs must work with the government to receive commodities from the national stock.

Referrals

Make sure that a point person at each clinic is trained to receive referrals. Also, develop a training plan to ensure that PEs are trained to accurately fill out tracking coupons, including UICs. Training on the use of data-tracking systems is also necessary for PEs and clinic staff members.

Utilize existing resources

If feasible, recruit PEs who are not only members of key populations, but who are also trained in the provision of PE services because of work in previous projects. Conduct a landscape analysis to map existing clinics. Finally, use tools and materials for project implementation that have worked successfully in similar projects to save time and resources.

Monitoring and evaluation

Train PEs to use tracking tools, including referral coupons, mapping sheets, and inventory sheets. Supervisors should check-in with PEs on a regular basis to ensure they are filling out all forms accurately and completely. Ensure that a staff member at each referral clinic acts as a point person for referrals from PEs, and is also trained in data-tracking systems and processes.

The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, oractions on the part of any person who appears in the photographs.

Innovation highlight: PACTE-VIH reaching key populations with mHealth

BACKGROUND

A growing body of evidence suggests that mHealth — the use of mobile devices in medical practices and public health — can enhance health programs and improve certain health outcomes. For example, mHealth is now used to encourage HIV testing, reduce risky sexual behavior, improve adherence to antiretroviral therapy (ART), and improve patient follow-up and retention.

Many policymakers and program managers also look to mHealth as a tool to address the special needs of key populations. At a 2013 meeting of representatives from USAID, PEPFAR, and the Foundation for AIDS Research, stakeholders discussed recent innovations and recommended areas for research and programming on the use of information and communication technologies (ICTs) for HIV prevention, care and treatment among key populations.[6]

In light of these developments, the PACTE-VIH project piloted the use of mHealth during its third year in Burkina Faso and Togo. We designed and implemented a two-pronged mHealth strategy that 1) provided health and lifestyle content to key populations via text messages and social-media platforms, and 2) allowed key populations to ask questions directly to trained counselors in one-on-one sessions through those same channels. The counselors could also provide key population members with referrals to local clinics or drop-in centers.

The popularity of the service — with nearly 3,000 users — indicates a strong interest in mHealth among key populations in Burkina Faso and Togo. Although the full impact of the mHealth strategy on the knowledge and behavior of the participants has yet to be assessed, the lessons learned through this effort should be of value to other programs that wish to implement an mHealth strategy.

DESIGNING AN MHEALTH STRATEGY IN FOUR STEPS

1. Developing, testing, and validating messages

We engaged an expert in social and behavior change communications (SBCC) to provide technical assistance and to coordinate the process of developing messages in conjunction with key populations and other stakeholders, including the Ministry of Health. The project developed messages that were tailored to each audience in a format and language that was easy to understand. Once the messages were formulated, they were pre-tested with a cross-section of recipients, and the SBCC expert facilitated a final session with key stakeholders to validate the messages.

2. Collecting mobile phone numbers

The mobile phone numbers of key population members were needed to push the standardized messages through the short-message service (SMS) format. First, the peer Educators (PEs) collected phone numbers from interested and consenting members of key populations during routine outreach activities before the mHealth strategy was deployed. The project also obtained phone numbers of key population members living with HIV from the Ministry of Health (which is perceived as a trusted source of information and services, particularly ART). We then created a database of these phone numbers after checking them for accuracy and deleting duplicates.

3. Training and equipping mHealth counselors

Implementing partners recruited PEs who were familiar with social media and mobile phones to act as mHealth counselors and to manage the use of social media sites — Facebook, Gay Romeo, Twitter — that are often visited by members of key populations. Although PACTE-VIH used previously trained PEs, mHealth counselors should be trained in the project subject matter — HIV/AIDS prevention, treatment and care, sexually transmitted infections (STIs), family planning, and gender norms — and in counseling techniques so they can provide high-quality counseling to their clients.

The mHealth counselors also received training and orientation on how to use different digital platforms and tools, including those needed for data collection and monitoring. Each mHealth counselor was provided with a smart phone, a registered SIM card, and monthly bundles for data and airtime. The mHealth counselors were also provided with a small, monthly stipend that was tied to their performance and the timely submission of reports.

4. Identifying technological partners

We selected a technological partner (based in Ghana) that was able to offer a Web-based SMS platform that could serve both countries with affordable bulk SMS rates. We considered partnering with mobile network operators to obtain free or reduced-price data and SMS rates, but this process can be long and cumbersome. We also learned that key populations were concerned about breaches in confidentiality — such as local SMS providers who might link their registered SIM cards to specific mHealth services. In light of these considerations, the group based in Ghana was the best choice for the project.

IMPLEMENTATION

We implemented the mHealth strategy in two phases. During the first year or so, we pushed the standardized content through SMS to the bank of collected phone numbers. After the first year, we used the push messages to promote the availability of mHealth counsellors who could answer individual questions and provide personalized counseling through various social media sites. Text messages, social-media sites, and flyers distributed by PEs identified the days and times when the counselors were available.

When individuals call, text, or message (via social media) an inquiry to an mHealth counselor, he or she provides as much information as possible. In some instances, mHealth counselors provide referrals for services using a unique identifier code (UIC) for each client — a system used by the project to maintain confidentiality (*For more information, see the UIC strategy highlight in the Peer Education Strategy section*). Counselors document the content that was discussed so that the messages to the key populations are continuously updated with the most relevant information. The counselor also makes monthly visits to the referral facilities to determine whether the referrals were completed.

CONCLUSION

PACTE-VIH's implementation of the mHealth strategy serves as a useful complement to other SBCC and outreach strategies that can contact individuals who are otherwise reluctant to engage in face-to-face interventions. Our implementation of the mHealth strategy will be formally assessed during the end-of-project evaluation.

The following resources should be useful to others who wish to design and implement an mHealth strategy:

- *mHealth Planning Guide*
- *mHealth Basics: Introduction to Mobile Technology for Health* eLearning Course
- *From Principles to Practice: Implementing the Principles for Digital Development*

II. DROP-IN CENTER STRATEGY

Drop-in centers (DICs) are open, friendly environments where key population members can receive referrals for services, attend group or one-on-one sensitization sessions, or receive social support free of stigma or discrimination. At DICs, key populations can easily access resources and information for risk reduction and HIV prevention. The functions of DICs may vary in relation to the capacity of each unique location, but their primary purpose should always be social gathering, sensitization for HIV and STI prevention services (including commodity distribution and sensitization sessions), and testing services for key populations.

Peer Education Strategy – A Snapshot

Step	Details
1. Activities in the PEd strategy	• Social support • SBCC • Voluntary counseling and testing (VCT) services • Commodity distribution • Referral services • Community pharmacy services • Other services
2. Stakeholders involved in supporting and implementing DIC strategy	• Government stakeholders • Facility-based staff • PEs • IPs • Managers of DICs • Case managers
3. Preparatory steps for the DIC strategy	• Choose a DIC site location • Recruitment and training • Monitoring and evaluation
4. Implementing the DIC strategy: detailed description	• Social support • SBCC • VCT services • Commodity distribution • Referral services • Other services provided by PEs
5. Challenges and facilitating factors in implementing clinic services	• Challenges: stock-outs, ownership by MSM, long hours, stigma and discrimination • Facilitating factors: Welcoming/enabling environment; attractive to key populations
6. Key considerations for replicating	• Choose a location and hours that provide easy access to DICs for key populations • Utilize existing resources • Ensure ample supply of commodities • Training PEs, facility-based staff, and DIC managers • Create an enabling environment

Photo 5: A PE at a drop-in center leads a training with MSM on self-esteem. Photo Credit: PACTE-VIH

1. Activities in the drop-in center strategy

The DIC strategy is comprised of six activities: social-support activities (including games and parties); VCT services; commodity distribution; distribution of SBCC information (which includes group and one-on-one sensitization sessions); referrals (to clinics); and pharmacy services (may only be available in some locations). Through activities like these, key populations can access services and information to reduce the transmission and risk of HIV and STI without facing stigma or discrimination.

2. Stakeholders involved in supporting and implementing the drop-in center strategy

The DICs may be established within existing clinics or as new, stand-alone locations in instances when partnerships with clinics cannot be established. Due to these variances, stakeholders (such as sub-partners) will likely vary per location as well. However, the following stakeholders are most likely to be involved with all of the DICs.

Government stakeholders

Government buy-in is essential across the PACTE-VIH project. However, government support specifically effects the DIC strategy by ensuring that key populations are safe when they visit DICs, and not subjected to violence or harassment from police.

Clinic service locations and facility-based staff

If possible, some DICs may be integrated directly into a clinic location; other DICs may be stand-alone, with clinic services offered nearby. The IPs should consider whether clinics already exist in a certain region, the locations of those facilities, and the clinic's capacity to determine where to implement a DIC site, and with which clinics to establish partnerships.

To determine where to establish DICs within clinics, IPs should map available clinic locations (through the landscape analysis), and consult with these locations to determine whether they have the available space and whether they are willing to host a DIC within their clinic. One primary advantage of having a DIC located within a clinic is that it reduces the likelihood that a key population member will be lost to follow-up after receiving a referral because he or she can go directly to another room within the clinic and receive testing and treatment services. For details, see the example from a sub-partner clinic in Togo.

The staff members at existing clinics should receive sensitivity training in order to offer comprehensive services to individuals who are referred to their clinics after visiting DICs.

(For more information on training clinic staff members, see the section on recruitment and training and the appendix for the training manual.)

Peer educators

The PEs are facilitators at DICs; they conduct scheduled group and one-on-one sensitivity sessions, provide referrals, and distribute condoms and lubricants. PEs also host occasional parties at DICs to encourage more (and new) individuals to visit the DICs.

(For more information on PEs, see the section above on PEs and the appendix for the PE training manual.)

Managers of drop-in centers

Through consulting with key population leaders, the IPs in Burkina Faso and Togo were able to select, recruit, and hire DIC managers who were members of key populations and had the capabilities, including technical capacity, to do the work. The role of the DIC manager is to oversee the logistical details of running the DIC (including all DIC activities) and to supervise PEs (including establishing chat or group themes and schedules for PEs) in a consistent, constructive manner.

Case managers

Case managers work within partner clinics, and they are selected from a pool of nurses and social workers. They link key population members diagnosed with HIV to services and they ensure ART adherence and care retention once the clients are linked to services. Prior to working with the project, case managers are required to attend a sensitivity training course (and refresher trainings) for working with key populations. Case managers also work closely with the medical staff to monitor the health of their clients, and they train and support community volunteers and PEs who conduct home-based care.

Gbonvié was established as a stand-alone DIC with the goal of creating a safe, friendly space where MSM can meet with each other and receive appropriate, competent services.

An Example of a Drop-in Center

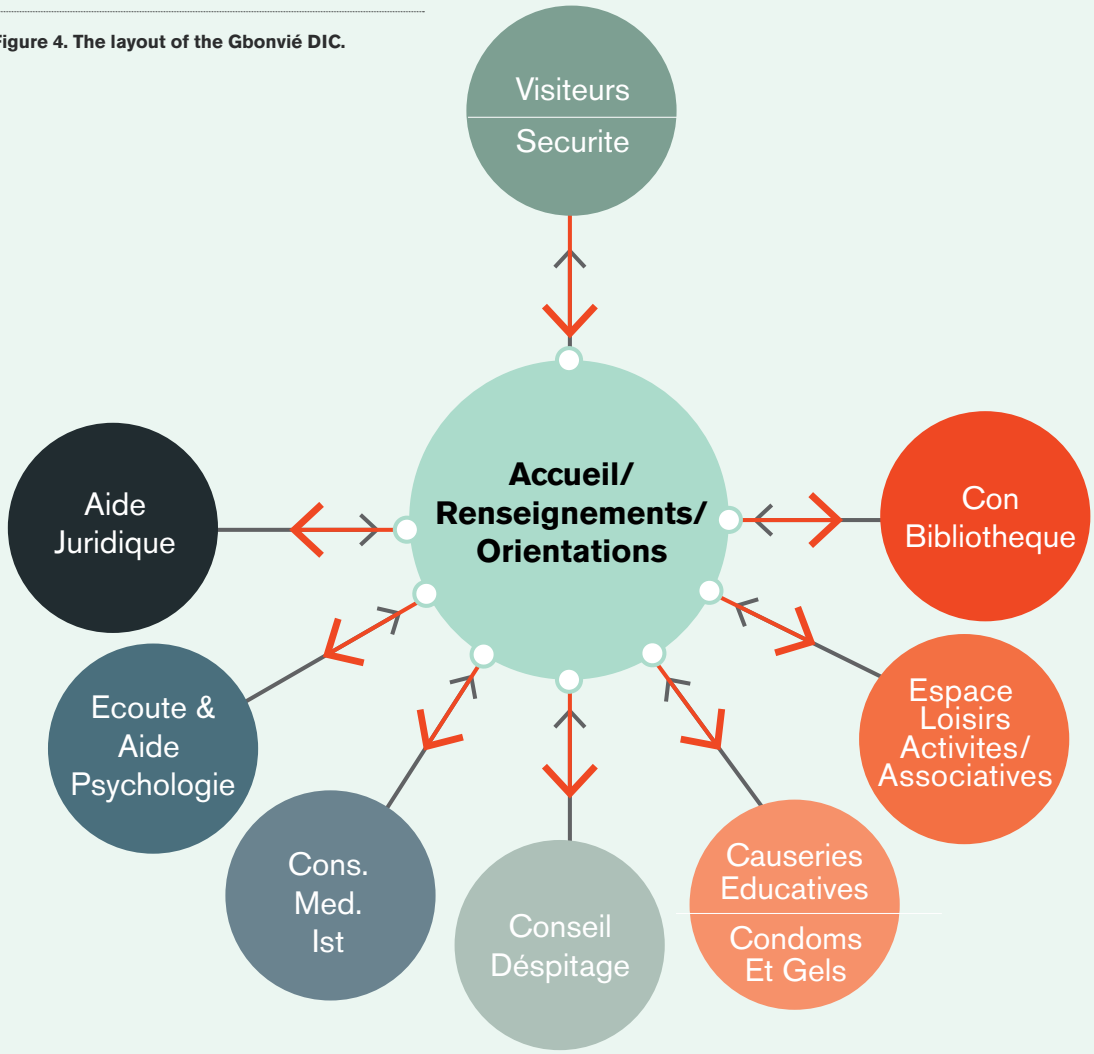
Gbonvié is open every Monday to Friday from 09:00 to 16:00, and has extended hours when there are parties or activities (during the week and sometimes during the weekends).

Three main services are offered at Gbonvié:

- Provision of a friendly space
  - » This includes a library and reading area with books, games, a relaxation area, a cybercafé with free Wi-Fi, a refreshment stand where soft drinks are sold at reduced cost, recreational activities, a men's theatre, and a cinema. Occasional parties, including food and music, are also held on certain holidays.
- Health services
  - » Available two days per week (Monday and Wednesday); facility-based health providers offer HIV-VCT, STI testing, and free treatment services. Because HIV rapid tests are used, individuals can learn their test results during the same on-site visit. If an individual tests positive for HIV, he or she is referred to a nearby clinic (either a customized services clinic or a sub-partner clinic). Case managers follow-up with individuals who test positive at the DIC to ensure they are retained in the HIV cascade framework. Awareness and sensitivity sessions are available during regular DIC hours. For PLWH, an adherence club is also available.
- Legal assistance and psychological support
  - » A legal assistant is available for consultation with key population members every Friday afternoon. Psychological support is offered twice a week with a licensed psychologist.

The Gbonvié DIC has seen nearly 4,000 visits from key population members in the Lomé region; It has distributed more than 8,000 condoms and lubricants, referred 167 people with symptoms of STIs, and provided VCT counseling (including disclosure of HIV test results) to 113 MSM.

Figure 4. The layout of the Gbonvié DIC.



3. Preparing for the drop-in center strategy

Choose the DIC site

All DIC locations should aim to have maximum impact on reaching key populations with HIV awareness, prevention, and treatment services (that are free of stigma and discrimination). The DICs should be easily accessible to key populations in the region, and "hotspot" locations are often a good choice. DIC locations can be determined through mapping or during the landscape analysis.

When determining whether DIC locations should be integrated within an existing health facility or stand-alone, IPs should consider the purpose of the DIC, and whether there are existing clinic locations nearby that are both easily accessible to key populations and have the capacity to provide services to key populations. Some DICs may choose to offer on-site testing, counseling, and treatment services in addition to social gathering because these services are not available at a nearby clinic. Other DICs may be used solely for social gathering, empowerment, and referrals — particularly if that DIC is part of, or very near to, a clinic location where testing, counseling, and treatment services are already offered. Over time, the PACTE-VIH projects in Burkina Faso and Togo learned that DICs that offered clinical and testing services (such as the DIC from the earlier example) had a better retention rate and attendance from key populations than those that did not offer these services.

(See the introduction for more information on mapping and the landscape analysis.)

Recruitment and training

Recruitment

The DIC staff includes DIC managers, PEs, and facility-based staff members (in cases where the DIC's partners are located within clinics, or refer key populations to nearby clinics for services). In Burkina Faso and Togo, the selection criteria required all DIC managers to be:

- Members of key populations (FSW or MSM)
- Between the ages of 25 and 40
- Graduates of a high school (or the local equivalent)
- Computer literate
- Experienced through previous work in a similar position
- Fluent in French and applicable local language(s)
- Experienced through previous work that provided services to PLWH or key populations
- Honest
- Welcoming with a warm disposition

Interested and eligible candidates must submit a letter of interest, a copy of their birth certificate, and a copy of their diploma to IPs (by email), who will contact top candidates for an interview. The most qualified candidates are selected for a 12-month post as the DIC manager.

(See the sections on PEs and the clinic services strategy for more information on recruiting PEs and clinic staff members.)

Development of the training manual

Before project implementation, all DIC staff (PEs, DIC managers, case managers and facility-based healthcare staff members, when applicable) received sensitivity and M&E training to ensure they could provide comprehensive, stigma-free services to key populations through DIC activities. The manual for training PEs can be adapted (to reflect local laws, customs, and norms) from a manual that was previously used for a project similar to PACTE-VIH. All facility-based staff members should be trained according to national standards for HIV testing and treatment, and should receive additional sensitivity training for work with key populations.

(See the appendix for the training manual for PEs.)

Training PEs, DIC managers, case managers, and facility-based staff

The PE training may occur at project headquarters, or in other locations to accommodate PEs according to the project's capacity. Training should include sessions on sensitivity, confidentiality, and safety, along with information about HIV and STIs.

(See the appendix for the training manual for PEs, and the section on PEs for more information on recruiting and working with PEs.)

Because DIC managers are also members of key populations and will be working directly with PEs, training for DIC managers will be similar to PE training, but it should also include an orientation on the logistical aspects of running the DIC, including scheduling, safety, and coordinating with facility-based staff. A training manual for DIC managers can be adapted from the PE training manual.

To reach as many applicable health care workers (HCWs) as possible, IPs may choose to implement training for facility-based staff members (from sub-partners and customized services) in various locations (including project headquarters and clinic sites). Training topics should include the national standards for the provision of HIV and STI testing, treatment, and care as well as sensitivity training for providing services to key population members who were referred from the DICs. Once sub-partners clinics and customized services clinics are established and sensitivity training is complete, clinics should be integrated into the DIC network of referrals, which includes an updated list (available to DIC managers and PEs).

Monitoring and evaluation

Capacity building, including bi-annual or annual training of DIC partners (facility-based staff members, clinic managers, case managers, and PEs) should be included by IPs in the project work plan, budget, and timeline.

Consider these indicators for the DIC strategy:

- Number of key population members reached with individual or small-group interventions that were based on evidence or met the minimum standards
- Number of individuals who visited a DIC
- Number of male condoms, female condoms, and lubricants distributed to FSW and MSM
- Number of individuals who received testing and counseling (T&C) services for HIV, who and received their tests result
- Number of individuals who accessed a service after a referral
- Number of individuals reached (key populations, health providers, community workers) with messages about stigma and discrimination

4. Implementing the drop-in center strategy: detailed description

The DICs should be safe, stigma-free spaces that are integrated into clinics or static spaces where key populations can receive social support, testing and treatment, SBCC, commodities, referrals, and pharmacy services. These activities are described below.

Photo 6: Local stakeholders participate in a meeting at a drop-in center. Photo Credit: PACTE-VIH (2015)

Social support

Social support activities can attract key populations to DICs, and may include free Internet access, socialization with peers, and fun games. Occasionally, DIC managers may also host parties at DICs, to allow for additional opportunities to reach key populations who may otherwise not know about DICs. Parties may include food, drink, games, and music. While participating in social support activities, key population members can also receive information from peers on STIs or HIV, gain access to condoms, and receive referrals to nearby clinics. The IPs should budget for the provision of free Internet, fun games, food, drink, and music (for parties) as needed for the project's plan.

Materials needed for social support services at DICs

- Fun games (can be donated stakeholders or community partners)
- Posters
- Food, music, and drink for parties
- Internet with a free access code
- Condoms and lubricants
- Referral coupons

Strategic behavior change communication

Group and one-on one sensitization occurs during parties, scheduled chat sessions, or at the request of the individuals visiting the DIC. The information delivered during these sessions is based on a discussion theme chosen by DIC managers or IPs. Discussion themes are consistent with the themes used by PEs during community outreach.

(For more information on themes for one-on-one or group sensitization sessions conducted by PEs, see the section on PEs, and the annex for the PE training manual.)

Materials needed for social support and SBCC services at DICs

- Fun games (can be donated by stakeholders or community partners)
- Posters
- Food, music, and drink for parties
- Internet with a free access code
- Condoms and lubricants
- Referral coupons
- Pamphlets/handouts that address key health issues: proper condom use, risk reduction, HIV and STI symptoms, gender-based violence and gender equity, self-esteem, and management of self-stigma (these themes are the same as those in PE outreach manual)

VCT services

Some DIC locations may offer on-site testing services, according to their capacity and available resources. When determining whether to offer testing services to key populations, IPs should consider available resources, including: temporary HCWs to conduct HIV and STI tests, nearby clinics that may also provide VCT services to key populations, and clinics where individuals can be referred for additional services if they test positive for HIV or STIs. The HCWs can be recruited from nearby clinics to provide on-site testing on a specific day, for example, one day per month. Trained case managers can provide VCT to individuals before testing, and will ideally disclose test results to the individual during the same visit (this is only applicable for rapid tests). If a rapid test is not available, then individuals should receive information when they return to the DIC to receive their test results (and counseled by a trained case manager when they return). If an individual tests positive for an STI or HIV, DICs should always aim to offer referrals to care services at nearby clinics. If available, DICs can also provide pharmacy services, where key populations can access STI-treatment prescriptions, or medication for other illnesses (if possible).

Commodity distribution at drop-in centers

Condoms and lubricants are distributed by PEs and DIC managers at DICs according to the national distribution guidelines. The procedures for stocking condoms may vary with the project's location. For example, in Burkina Faso and Togo, commodities were acquired from the national stock, and distributed by IPs to each DIC site in numbers that would accommodate the demand from that particular site.

Depending on national guidelines for condom distribution, individuals may receive commodities for free after participating in group or one-on-one sensitization sessions, VCT, or attending parties. Some national guidelines may not require individuals to participate in any of these sessions before receiving commodities; and in these circumstances, condoms and lubricants can be made freely available at the reception area for individuals who visit the DICs. The PEs should track the number of commodities (for example, in a logbook) distributed in accordance with the M&E procedures for the project.

(For more information on developing a logistical plan for commodity distribution, see the commodity distribution section in the peer education strategy.)

Referral services at drop-in centers

The individuals who attend DICs that do not offer testing and treatment services should be referred by PEs or DIC managers to nearby clinics (or other service locations, including mobile clinics) to receive the desired services. Similar to the PE outreach referral process, these individuals receive a referral coupon with a UIC number and the location of a specific clinic. A trained point person at that clinic will complete the patient-intake process when the individual reports for services, and track the services he or she receives. The PE should be responsible for tracking the number of individuals they referred for services.

(For more information on UICs, referrals, or clinic services see the sections on the clinic services and the peer education strategy. For an example of a referral coupon, see the appendix.)

Materials needed for VCT services, commodity distribution, and referral services at DICs

- Pamphlets/handouts that address key health issues: proper condom use, risk reduction, HIV and STI symptoms, gender-based violence and gender equity, self-esteem, and management of self-stigma (same as those for PE outreach)
- Logbook for tracking patient's test results, number of commodities distributed, and documenting referrals
- Referral coupons if patients test positive for HIV
- Male and female condoms and lubricants
- Clinic supplies
- STI testing kits
- HIV testing supplies
- Condoms (male and female)
- Lubricants
- Logbook for tracking number of commodities distributed
- Referral coupons (including a space for UIC codes)
- Logbook for documenting referrals

Other services provided by drop-in centers

Other services provided by DICs may vary at each site. These services may include: training on how to manage finances and open a bank account, legal assistance, assistance finding employment, family planning services (for FSWs), and PE training.

5. Challenges and facilitating factors for the DIC strategy

Challenges

The IPs may encounter some of the following challenges during the DIC strategy planning and implementation phases. These issues should be considered in the project's work plan and budget to prevent unnecessary roadblocks and challenges.

Stock-outs

Shortages of test supplies for STIs and HIV, STI medications, condoms, and lubricants may result from a lack of planning (for budget or supplies) or a lack of coordination or cooperation with the government to ensure adequate supplies.

Long hours

In order for DICs to be easily accessible to the key populations they serve, some DICs may need to be open longer hours, or later in the day and into evening hours, which could be difficult for the DIC manager or the PEs at the DICs.

Stigma and discrimination

Stigma and discrimination, including violence and harassment, may discourage visits to DICS by individuals (particularly MSM). When DICs are known to provide services solely to key populations, MSM may be "outed" for visiting these locations. In these instances, the IPs can adjust the DIC strategy to provide services in smaller or private locations (such as a person's home), or provide one-on-one sensitization and commodity distribution services in clinics or hospitals that are safe and free of stigma and discrimination.

Facilitating factors

The following considerations helped IPs to successfully implement the DIC strategy in Burkina Faso and Togo, and they can provide guidance to future project implementers on how to leverage key strategies for successful implementation.

Welcoming and enabling environment

A safe, welcoming, enabling environment for key populations, encourages individuals to visit DICs. This increases their access to services, and can encourage discussions about DICs with other key population members. This environment can be created by (a) hiring qualified PEs as DIC staff members who provide friendly, competent services; (b) conducting sensitivity training for all DIC managers, facility-based staff members (from sub-partner clinics and customized service clinics), and PEs; (c) ensuring that DICs sites are safe and easy to access for key populations (with long hours); and (d) by having occasional parties and group gatherings with food and games for the key populations.

The IPs and core project managers should also develop relationships with religious authorities, which may help to limit stigma in the region. In Togo, investment from a religious stakeholder resulted in the donation of games and resources for a DIC. This relationship can be developed through sensitivity trainings and investment from a local religious "champion" who supports the DIC and denounces stigma against key populations in the community.

(For more information on creating an enabling environment, see the section on enabling environment.)

Making DICs attractive to key populations

DIC managers can work in collaboration with PEs, PE leaders, and IPs to develop a number of activities, resources, and services that attract key populations to the DIC.

As previously mentioned, these activities and services might include games and parties, social gathering places, books, or free Internet. All DIC activities, resources, and services should be adapted to accommodate the specific needs and desires of the particular key population they serve as well as the regional laws, norms, and customs.

6. Considerations for replicating the DIC strategy

These five items (see box below) are absolutely critical for ensuring successful implementation of the DIC strategy. The list includes essential factors to anticipate and overcome, and potential adaptations to adopt when replicating the DIC strategy.

1. Choose a location and hours that make DICs provide easy access for key populations
2. Utilize existing resources
3. Ensure an ample supply of commodities
4. Training DIC managers, key populations, case managers, and facility-based staff
5. Create an enabling environment

Choose a location and hours that provide easy access to DICs

The ideal location for a DIC is in an established hotspot (found during mapping by IPs and PEs during outreach). The operating hours should accommodate the schedules of key populations to increase the likelihood that they will visit the DICs. Even if the DIC is being integrated into an existing clinic, accommodating key populations with longer hours may still be necessary.

Utilize existing resources

As with the PEd strategy, surveying the current landscape is essential to prevent oversaturation or unnecessary expenditure of materials. If a clinic already exists in a particular region that has the capacity to provide services to key populations, IPs should consider partnering with that clinic to establish a DIC within the clinic or nearby to ensure that key populations receive clinic services when they are referred from stand-alone DICs. The PEs who have already been trained and worked for other HIV or STI outreach projects for key populations are ideal candidates for the DIC staff, and should be recruited (if possible). This method will ensure less time and resources are used on training only new PEs (who have never conducted outreach activities or provided DIC services before).

Ensure an ample supply of commodities

As with the PEd strategy, IPs should develop a logistical supply chain to prevent stock-outs. This may include accommodating country policies and procedures for condom procurement, and it will likely require support from government stakeholders.

Training peer educators, facility-based staff, and DIC managers

You will need to conduct sensitivity and logistical trainings for DIC staff members, PEs, and facility-based staff members (if applicable). This may include technical training for service provision to key populations, training on M&E processes and procedures, and sensitivity training.

(See the annex for the PE training manual.)

Create an enabling environment

Ensure the DIC is in a location that is safe and has an environment that is free of stigma and discrimination. To create an enabling environment, you will need to conduct sensitivity training for the DIC staff and facility-based staff members (from sub-partner clinics and customized service clinics), map safe and accessible locations for key populations, and coordinate with government and religious stakeholders.

(For more information, see the section on enabling environment.)

III. CLINIC SERVICES STRATEGY

Through the clinic services strategy, IPs can strategically utilize existing resources and expand the network of sensitized clinics and resources available for key populations in the region of project implementation. A greater number of key populations will then be engaged in the HIV cascade framework, as well as connected to other resources (such as DICs and PEs) for prevention and health education services in the future.

Through the landscape analysis, IPs can determine which clinics in the region have the capacity to provide testing, treatment, and care services to key populations. Ideally, IPs should work with clinics in regions with a high prevalence of HIV or STIs, a large numbers of key population individuals, or both.

The PACTE VIH project found that some of the identified clinics already provided services to key population groups, whereas other clinics provided services only to the general population. Also, each clinic's capacity to provide quality services to key populations varied. The IPs can form partnerships with selected clinics to achieve the goals for their outreach indicators, such as adding or strengthening services for key populations, providing awareness and sensitivity training for HCWs, or supporting additional staff members. Once these partners have been determined, IPs can develop a list of all eligible clinics for PE referrals and the delivery of health services to key populations. All clinic staff members (including healthcare workers, secretaries, and cleaning staff) should receive appropriate training services before the clinic joins the referral list for PEs and DICs.

In addition to standalone clinics, mobile clinic services, using HCW staff from clinic locations, can provide clinic services to key populations in regions (particularly hotspots) where standalone clinics cannot be feasibly accessed by key populations.

Step	Details
1. Activities in the clinic services strategy	• STI testing and treatment • Family planning services • HIV testing, treatment, and support • Community pharmacy • Commodity distribution • General medical consultation
2. Stakeholders involved in supporting and implementing clinic services strategy	• Government stakeholders • Facility-based staff • Midwives • Peer Educators • Case managers
3. Preparatory steps for the clinic services strategy	• Identify locations for clinic services strategy implementation • Recruitment and training • Monitoring and Evaluation
4. Implementing the clinic services strategy: detailed description	• Sub-partner clinic • Customized services clinic • Mobile clinics • STI testing and treatment • Family planning services • HIV testing, treatment, and support
5. Challenges and facilitating factors in the clinic services strategy	• Challenges: Stock outs, stigma and discrimination, confidentiality, loss to follow-up • Facilitating factors: clinic Location, referrals, welcoming/enabling environment, targeted prevention efforts
6. Key considerations for replicating he clinic services strategy	• Go where the need is greatest • Utilize existing resources • Government buy-in • Accessibility of clinics • Ensure ample supply of commodities • Training PEs, case managers, and facility-based staff

1. Activities in the clinic services strategy

The clinic services strategy is in line with the UNAIDS 90-90-90 goals, and it targets gaps in testing, treatment, and retention in care for key populations through the HIV-cascade framework. In addition to HIV testing, treatment, care, and support services, the clinic services strategy also provides STI testing and treatment, and family planning services. Integrated within these strategies are additional features, which may include a community pharmacy (available according to the capacity of individual clinics), commodity distribution, training and sensitization of the clinic's staff and providers, and general medical consultations for key population members who wish to be tested.

2. Stakeholders involved in supporting and implementing the clinic services strategy

Through the landscape analysis, IPs can identify existing clinics and categorize them according to the additional support (technical, staffing, and infrastructure) they require to offer comprehensive services to key populations. Although the stakeholders for the clinics may vary by location, the stakeholders listed below will likely be involved across the clinic services strategy.

Government stakeholders

Although government buy-in is essential to the PACTE-VIH project, it is important to emphasize that the staff members at government-run clinics should receive the same sensitivity training that is provided at non-government-run clinics. This will enable them to provide comprehensive, competent testing, treatment, and care services to all key population members who are referred to these locations. Government stakeholders may also be essential for successful commodity distribution to the clinics and to ensure ample supplies for tests.

Facility-based staff

Medical providers — including nurses, doctors, and medical assistants — work within stand-alone clinics and mobile clinics to offer HIV and STI testing, general medical consultations, and treatment services for people living with HIV. Medical providers may also work with PEs to visit hotspots to establish a rapport with key populations and key population leaders. This will increase the likelihood that key populations will visit clinics or access mobile services, because they will be reassured by the medical providers that they will not face stigma or discrimination at the clinic.

Facility-based staff members should receive key population sensitivity training before IPs consider referring members of key populations to these locations. Medical providers who specialize in HIV or STIs should also receive sensitivity training to eliminate any chance of discrimination in clinical settings. Providers who already offer services to key populations can also benefit from technical training or updates to ensure that their services are of the highest technical quality. Training topics may include sensitivity training for managing and diagnosing STIs in key populations, prescribing ARTs, providing family planning services, engaging key populations through the HIV cascade framework, confidentiality, and training on M&E and data collection.

Midwives

When applicable, midwives can also work in clinic locations to provide medical consultations, assist with M&E, track key population data, and provide family planning and counseling services (to FSWs).

Peer educators

Through the DIC and PE outreach strategies, PEs provide referrals for clinical services. Some HCWs work directly modules on the management with medical providers and facility-based staff to deliver key population-friendly services at clinics and PEs conduct sensitivity trainings.

(See the PEs strategy section for more information on utilizing PEs.)

Case Managers

Case managers work within partner clinics, and are selected from a pool of nurses and social workers to link key populations diagnosed with HIV to services, and to ensure ART adherence and care retention once they are linked to services. Prior to working with the project, case managers are required to attend a sensitivity training course (and refresher trainings) for working with key populations. Case managers also work closely with the medical staff to monitor the health of their clients, and train and support community volunteers and PEs who have conducted home-based care.

3. Preparing for the clinic services strategy

Identify clinic locations

As mentioned previously in this toolkit, clinic locations can be identified through a landscape analysis or an ongoing mapping process. After identifying clinics as potential partners, IPs should consult with these clinics to ensure they have the space and capacity to provide essential services (designated by the project) to key populations. In Burkina Faso and Togo, some clinics were provided with designated space within the clinic to provide services to key populations, while others supported the renovation of unused spaces (one or more rooms) to provide services to key populations.

Through the situational analysis, the PACTE-VIH project identified the geographical locations that lacked coverage of services for key populations and the available clinics or structures. Some of these clinics had been used previously for key population activities but no longer did so when the funding ended. This situational analysis was preceded by a study on size estimation that also helped identify HIV and STI prevalence among key populations in different regions of the country. The PACTE-VIH project used these results to determine priority regions for service provision. Using a capacity evaluation tool from FHI 360, clinics in these regions were assessed for their capacity to provide services to key populations. They were then provided the training, supplies, and staff needed to meet project standards. Once a clinic was declared to be adequate, it was added to a reference list of locations for key population referrals.

(See the annex for an example of the clinic capacity evaluation tool.)

Recruitment and training

Recruiting clinic staff

The recruiting process will likely vary with location. Ideally, clinic services for key populations should be integrated into existing clinics with providers who already work at those clinics. However, some circumstances (e.g., limited support from clinics, discrimination by existing providers) may make it difficult to work with existing providers. In these cases, it may be necessary to recruit providers who work only with key populations in separate rooms or areas of a clinic. However, if IPs do hire such providers, they should be wary of drawing unwanted attention from other patrons of the clinic who might have discriminatory attitudes toward key populations.

A clinic in Burkina Faso originally hired one doctor and one nurse to work solely with key populations. Although this allowed key population members to receive services quickly (and created the potential for customized services), key population members refused to attend the clinic because they were afraid that seeing the designated provider would reveal their identity as a key population member. Also, when the designated medical staff did not provide services to other patients, these patients became frustrated and questioned why that doctor was not attending to them.

Recruiting PEs to work with clinic staff and provide referrals

The PEs are the primary source for providing clinic referrals to key populations. Referral coupons are provided during community outreach, home and hospital visits, and at DICs. The PEs can also assist with sensitivity training for clinic staff. The PEs may be recruited using SNS, and trained to provide services to key populations in their region.

(See the PEs strategy section for more information about the recruiting process for PEs.)

Training clinic staff

All clinic staff members, including health care staff, secretaries, and cleaning staff, should receive sensitivity training and applicable technical trainings to provide comprehensive, competent services to key populations. Core management staff members and IPs may plan for sensitivity workshops (and annual refresher courses) prior to project implementation. Content for technical training sessions may include data tracking and patient documentation, HIV and STI information training, training for counseling, and competent, comprehensive provision of care and services for people living with HIV. The PACTE-VIH project training for HIV and STI care was based on national standards for providing care, and sensitivity training for working with key populations was adapted from a training manual used by a previously implemented project similar to PACTE-VIH.

(See the annex for the *training manual* on sensitivity training for working with key populations.)

Monitoring and evaluation

All clinics and clinic staff members, including healthcare staff, and secretaries should be trained to use a database for monitoring the patient's test results, demographic information, and health information. The PACTE-VIH project used these monitoring and evaluation indicators:

- Number of partner clinics offering prevention services and care to key population members who were referred under the project.
- Number of condoms distributed to key population members
- Number of lubricants distributed to key population members
- Number of key population members who received STI counseling
- Proportion of positive cases of STIs treated among key population members
- Number of key population members who tested HIV positive and were linked to care
- Number of key population members who tested HIV positive and who received support for their pre-treatment assessment
- Percentage of HIV-positive key population members who were assessed for ART eligibility through CD4 counts
- Number of key population members currently receiving ART
- Number of key population members who were newly enrolled on ART
- Percentage of ART patients with a viral load result that was documented in the medical record within the past 12 months
- Proportion of viral load tests with an undetectable viral load
- Number of PLWHA lost to follow-up
- Number of people (PLWH and key population members) lost to follow-up, then found
- Number of people (PLWH and key population members) who received psychological support
- Number of people (PLWH and key population members) who received psychosocial support
- Number of people (PLWH and key population members) benefiting from support groups accompanied by friendly meals

- Number of people (PLWH and key population members) benefiting from nutritional advice
- Number of people (PLWH and key population members) who have benefited from a nutritional kit
- Number of people (PLWH and key population members) who received medical care

4. Implementing the clinic services strategy: detailed description

Clinic services can be implemented in stand-alone and mobile clinic settings. Services offered by stand-alone clinics include testing and treatment for STIs, HIV testing, treatment, and care (including psychological care), and family planning services. A more comprehensive package of services is usually offered through stand-alone clinics, and ideally all key population members should visit stand-alone clinics, but mobile clinics are a viable alternative for VCT and testing services, STI treatment and family planning services for individuals who cannot access stand-alone clinics.

Mobile clinics

Mobile clinics are used to reach key populations that cannot access stand-alone clinics for the provision of VCT services, rapid tests, and referrals to stand-alone clinics for additional services. Mobile clinics are generally housed in a large van or trailer, and travel to hotspot areas with HCWs or providers from local clinics that provide services to key populations. The PEs work with those providers to introduce them to key population members in the community where they are conducting outreach to establish familiarity and to ensure key populations that they will not be stigmatized if they present for testing or other services.

Photo 7: A mobile health clinic truck delivering services in Togo. Photo Credit: PACTE-VIH (2015).

Materials needed for STI testing and treatment

- STI testing kits
- Referral coupons and tracking sheets
- Register sheets (to gather patient demographic information, medical information, and test results)
- Condoms
- Lubricants
- Manual with protocols for testing and treatment of STIs
- Posters, pamphlets, and SBCC materials for counseling

Testing and treatment for sexually transmitted infections

Protocols for STI testing may vary among countries according to national testing policy and standard operating procedures. Prior to testing, trained facility-based staff members (or mobile clinic staff members) can provide STI consultation to key population members as well as document the individual's demographic and medical information. When possible, the clinic staff should also provide SBCC to key populations who present for testing. If implemented effectively, STI testing and treatment can be an extremely effective aspect of the clinic services strategy. For example, in Year 3 of project implementation in Burkina Faso, 68% of the key population members screened for STIs were diagnosed and treated for an STI, and in Togo 57% respectively.

Referral coupons include the individual's UIC, which tracks test results while maintaining confidentiality. A clinic staff member should record the UIC in a data-tracking system, which will help to track any subsequent test results or visits to the clinic for that patient. Whenever possible, test results should be made available immediately, and the patient should be notified of results on the same day of testing to prevent loss to follow-up.

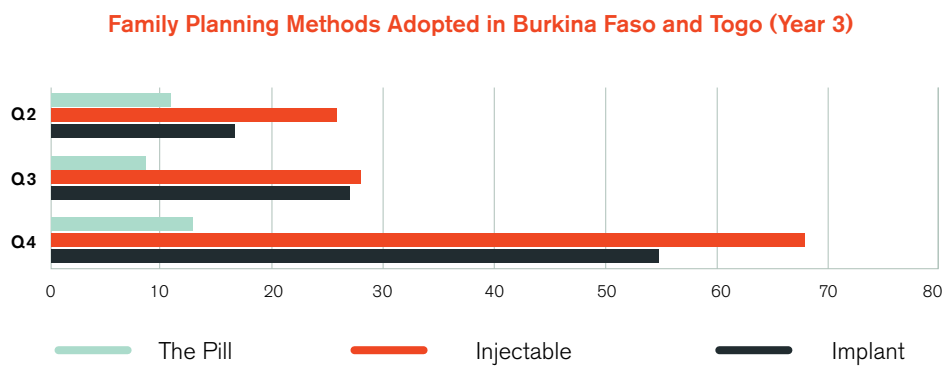
If a patient tests positive for an STI, he or she should receive follow-up, including a prescription for treatment medication and the appropriate referrals to receive care and services. If a patient tests negative, the clinic staff should provide the individual with referrals, including a referral to a DIC if they have not visited one already. Regardless of test results, the clinic staff should strive to distribute condoms and lubricants to all individuals who visit the clinic. All patient data (including all information from referral coupons) should be recorded throughout the day on data-tracking sheets (or through another viable tracking system) and verified on a daily basis. The staff should also log the number of condoms and lubricants distributed to each patient on data-tracking sheets in order to maintain the logistical supply chain.

(See the annex for examples of data-tracking sheets, SBCC materials, and the manual of procedures and processes for the PACTE-VIH project.)

Family planning services

Family planning services may include awareness sessions for FSWs and the distribution of contraceptives, according to the client's preferences and availability. The PACTE-VIH project provided hormonal contraceptives (Injectables, implants, and contraceptive pills) to FSWs free of charge in addition to male and female condoms. The chart below demonstrates the family planning methods distributed during Year 3 for the PACTE-VIH project in Burkina Faso and Togo:

Figure 5. Family planning methods adopted in Burkina Faso and Togo.



HIV testing, treatment, care, and support services

The PACTE-VIH project aligned their HIV testing, treatment, care and support strategy with the UNAIDS 90-90-90 goals using the HIV cascade framework (described in the introduction of the toolkit). Using this model, IPs can assess the total number of people living with HIV in the region, and subsequently implement strategic methods to engage key populations in testing for HIV, engage and retain PLWH in care, and eventually achieve viral-load suppression for PLWH. Sub-partner clinics and customized service clinics can use indicators from the HIV cascade framework to track project targets for testing, treatment, and retention in care.

Using the outreach and referral coupon systems, PEs can refer key population members to stand-alone and mobile clinics for HIV testing. The clinic staff should document the individual's UIC code (from the referral coupon), and provide VCT services before testing. As with STI testing, the clinic staff should document the patient's demographic data on a data-tracking sheet, including whether that patient has previously been tested for HIV. To maintain confidentiality, only the patient's UIC code (not his or her name) should be documented in association with the test results. Ideally, post-test counseling should take place immediately after the test results are available, during the same clinic visit, to prevent loss to follow-up. As with STI testing and treatment, the facility-based staff should strive to distribute condoms and lubricants to all individuals who visit the clinic, regardless of their test results. Applicable patient data should be recorded by providers on a register and entered into the clinic's database by the end of the day.

The project should immediately engage individuals who test positive for HIV into care and through the cascade framework to achieve viral-load suppression, in alignment with the 90-90-90 goals. The PACTE-VIH project achieved this through a three-part system: initial testing and disclosure of test results, ART counseling and monthly visits with a case manager and provider to ensure ARTs are working, and follow-up for patients who do not return to the clinic after receiving their test results, or after starting ARTs.

Once an individual learns his or her HIV status, the providers or HCWs should set an initial appointment for him or her to meet with a case manager and psychologist (if available) to be counseled on the next steps for accessing and maintaining treatment and care. The individual should receive a medical consultation and initial blood samples are collected (including CD4 count and pre-therapeutic check-up samples, in line with global indicators for initiating ART). At this same appointment, the individual should also receive psychosocial care (to discuss possible frustrations, questions, and concerns related to their diagnosis). If an individual does not return for a subsequent visit after receiving their diagnosis, the information is recorded into a system for follow-up, where the case manager has 60 days to attempt to locate the patient and convince him or her to return to the health center to initiate ARTs. If the patient is not found after the 30-day period, he or she is documented as "patient on alert and missing before ART." If the patient is not found after 60 days, he or she is documented as "out of sight before ART" and is placed at the beginning of the cascade if he or she returns to the clinic after the 60-day window.

Individuals who return to the clinic after diagnosis for a second appointment should initiate ART. This appointment includes another visit with a psychologist and a consultation with a medical provider to address other medical issues (STIs, for example) in accordance with national standards. The ARTs are monitored by a "therapeutic committee" that determines the dosage, frequency, and type of ART regimen for each patient (based on blood work).

Materials for HIV testing, treatment and support

- Rapid HIV testing supplies
- HIV testing kits
- Condoms
- Lubricants
- Referral coupons
- Nutrition kits for PLWH
- Register and data-tracking sheets (to gather patient demographic information, medical information, and test results)
- Manual with protocols for testing and treatment of HIV
- Poster and handouts for VCT services

The individual then attends an ART session with a provider where they are counseled on the importance of adherence and develop a plan for the best times to take ARTs. They also work with a case manager to set up monthly appointments and exchange contact information (ensuring the provider and case manager have the most accurate contact information for the individual, and ensuring the individual has the location, hours, and phone numbers of the clinic).

After the individual is aligned into care, the process of retention begins. Records of expected appointments are tracked by case managers. If an individual fails to renew an appointment, or fails to appear for a scheduled appointment, he or she is documented as "missing under ART" and the case manager uses all means possible to track down the patient. If the individual is tracked down within six months, his or her file is marked "missing but found under ART," and if he or she is not found, the patient is documented as "definitely missing." Individuals who abandon treatment are removed from the active patient list that is monitored by the case manager. When an individual requests a referral to another clinic or health center, he or she is still monitored by the case manager to ensure attendance at the initial appointment. Individuals who cannot afford transportation are reimbursed for transportation expenses.

In Togo, the FAMME clinic provides HIV and STI testing, care, and treatment services for FSWs. After a thorough assessment, the IPs determined that this clinic location was ideal for a DIC. Using extra space in the clinic's courtyard, the DIC hosts FSWs for social gatherings, sensitivity sessions, distribution of condoms and lubricants, and referrals. Once FSWs receive a referral from the FAMME DIC, they report to another room within the clinic for applicable testing and treatment services. The clinic staff at FAMME have received sensitivity training to provide FSWs with comprehensive, non-discriminatory services. This system reduces the likelihood that FSWs will be lost to follow-up, ensures FSWs in Togo receive services at a site that is free of stigma and discrimination, and it allows FSWs to receive comprehensive testing and treatment services, including follow-up care services when applicable.

Photo 8: A KP receives a consultation before being tested at a local clinic. Photo Credit: PACTE-VIH (2015)

5. Challenges and facilitating factors for the clinic services strateg

Challenges

The IPs may encounter the following challenges during the planning and implementation phases. These issues should be considered in the project's work plan and budget to prevent unnecessary roadblocks and challenges.

Stock-outs

Shortages of test supplies for STIs and HIV, STI medications, condoms, and lubricants may result from a lack of planning (for budget or supplies) or a lack of coordination or cooperation with the government to ensure adequate supplies.

Stigma and discrimination

Stigma and discrimination against key populations can hinder visits to the clinics. Individuals may fear that they will be recognized as a key population member, which could result in violent or negative consequences. In other cases, people living with HIV (PWLH) may not want to reveal their HIV status or that they are a member of a key population. They may have difficulties visiting a facility dedicated to PLWH or a clinic with a separate room designated for PLWH or key populations.

Stigma and discrimination by providers is also a concern. Some clinic staff members may not feel comfortable treating or caring for MSM. However, sensitivity training can reduce these fears by encouraging a compassionate approach and professional manner by all clinic staff members.

Confidentiality

Although all providers receive training on maintaining patient confidentiality, IPs should remain vigilant to ensure that UIC codes are always used, and that confidentiality is never compromised.

Loss to follow-up

For individuals who test positive for HIV, or who are already living with HIV, loss to follow-up for care, treatment, and support can still happen. In many cases, this is because 1) key population members are often highly mobile, 2) the double stigma and discrimination faced by key population members who are also living with HIV can increase depression and decrease the likelihood of returning for care, and 3) key population members who are living with HIV may fear their confidentiality will be compromised if they regularly visit an HIV clinic or a clinic designated for key populations.

Facilitating Factors

The following considerations helped IPs successfully implement the clinic services strategy in Burkina Faso and Togo, and they can provide guidance to future project implementers on how to leverage key strategies for successful implementation.

Clinic location

By performing a landscape analysis and mapping the clinic locations prior to project implementation, IPs can determine ideal locations to implement the clinic services strategy based on the capacity and availability of clinic facilities, the prevalence of HIV and STIs, and the number of key population members in a designated region.

Referrals

Through PE referrals, clinics can reach more key population members than they would without referrals. The referral system also encourages confidential, thorough, and accurate monitoring through the UIC system and the referral coupon method.

Welcoming and enabling environment

Sensitivity training for providers and the clinic's staff encourages an enabling environment and can potentially increase the number of key population members who receive counseling, testing, and treatment. Some clinic providers may work with PEs to visit key population members in the community to establish a sense of familiarity for the individuals with the providers who will test and treat them in the clinic. The PEs also work with the clinic staff to assist with sensitivity training for providing services to key populations.

Targeted prevention efforts

When they present at the clinic, key population members should receive free condoms and lubricants in addition to counseling and information services tailored to their unique concerns and lifestyles. This may include information sessions on: condom application using a phallus, proper use (and types) of lubricants, and HIV and STI counseling and sensitization.

6. Considerations for replicating the clinic services strategy

These six items (see box below) are absolutely critical for ensuring successful implementation of the clinic services strategy. The list includes essential factors to anticipate and overcome, and potential adaptations to adopt when replicating the clinic services strategy.

1. Go where the need is greatest
2. Utilize existing resources
3. Government buy-in
4. Clinic accessibility
5. Ensure an ample supply of commodities
6. Train PEs, and the clinic's staff (including healthcare staff, secretaries, and cleaning staff)

Go where the need is greatest

As with the PE strategy, surveying the current landscape in the region during the project planning stage is essential to prevent oversaturation and unnecessary expenditure of materials. An evaluation tool or previous analysis can help to determine where clinic services for key populations are needed most and which existing clinics need capacity building to provide services to key populations.

Utilize existing resources

It is important to determine the current capacity and availability of clinics in a given region. Existing clinics can be determined through mapping and clinic assessment. Clinics should also be assessed to determine whether the staff is already trained to provide services for key populations, and this will prevent the expenditure of undue time and resources that would otherwise be used in training new clinic staff members. A clinic assessment tool can help with this evaluation.

(See the annex for the clinic staff assessment tool.)

Government buy-in

As with all elements of the PACTE-VIH project, government buy-in is essential to ensure project success. For strategy implementation, government buy-in can increase the likelihood for clinic cooperation, decrease violence and stigma in regions surrounding clinics, and ensure that stock-outs do not occur.

Clinic accessibility

Accessibility to clinics can be determined by mapping hotspot locations. Clinics that are strategically located are more likely to be accessed by key populations. Clinics partners may also consider additional hours of operation to accommodate the schedules of key populations.

Ensure ample supply of commodities

Ensure that clinics are stocked with condoms, lubricants, and HIV and STI testing and treatment supplies, by establishing a budget for these supplies in the project plan, developing a logistical supply chain, and securing a relationship with government stakeholders who might determine the number of supplies the project receives.

Train PEs and the clinic staff (including healthcare workers, secretaries, and the cleaning staff)

Sensitivity training and technical training of all key stakeholders is necessary. This includes technical training on testing and counseling specific to key populations, M&E training (including database utilization and management), and sensitivity workshops. Sensitivity training for clinic staff members will help to create a welcoming environment within the clinic that is free of stigma and discrimination against key populations.

(See the section on enabling environment for more information.)

IV. ENABLING ENVIRONMENT

An enabling environment is essential to reach key population members who are often marginalized in society. As defined by the SEED model, an enabling environment is a "policy, project, and community environment, coupled with social and gender norms, [which] support[s] functioning health systems and facilitate[s] healthy behaviors." Before project implementation, IPs and core project managers should identify existing policies that might foster or inhibit key population programming. Subsequently, regional and national stakeholders — journalists and other media representatives, police and security officials, government officials, community-based organizations, and religious leaders — must be strengthened in their human and institutional capacities to plan, coordinate, deliver, and monitor service delivery for key populations.

Enabling Environment Strategy – A Snapshot

Step	Details
1. Activities to create an enabling environment	• Policy development and advocacy • Media strategy • Empowerment • General partnership/stakeholder capacity building
2. Stakeholders involved in supporting and creating the enabling environment	• Journalists and media representatives • Police and other security officials • Religious leaders
3. Preparatory steps for creating an enabling environment	• Policy assessment and landscape analysis • Identify key stakeholders • M&E
4. Implementing an enabling environment strategy	• Advocacy for policy creation and policy change • Media strategy • Empowerment
5. Challenges and facilitating factors in an enabling environment	• Challenges: lack of funding, stigma and discrimination, reluctance from media representatives and journalists, lack of government buy-in • Facilitating factors: development of a national strategy, development of a charter of journalists, development of an advocacy strategy, cooperation from key stakeholders
6. Key considerations for replicating the creation of an enabling environment	• Collect the necessary information to tailor strategies for supporting an enabling environment • Ensure adequate resources • Develop strategies and materials for advocacy in collaboration with key stakeholders

All PACTE-VIH project activities are more feasible once an enabling environment is established by widening the circuit of services available to key populations, increasing access to testing and treatment, and (possibly) decreasing stigma, discrimination, violence, and harassment toward key populations in general.

1. Summary of activities in creating an enabling environment

To create an enabling environment for key populations in the region, IPs should focus on four core activities and adapt these activities to meet the needs of the region. These activities include policy development and advocacy for key populations, a strategy for changing the way key populations and key population issues are portrayed in the media, empowerment activities that directly address key populations, and partnerships with stakeholders — including capacity building.

2. Stakeholders involved in creating an enabling environment

Key stakeholders for creating an enabling environment may be at national, regional, and community levels. A landscape analysis can help IPs determine which existing policies and legislation might support or hinder key population programming. As with all other project strategies, the landscape analysis should be conducted prior to project implementation, and it should also evaluate the capacity of community-based organizations, journalists and media representatives, religious leaders, and government officials in order to understand the opportunities and considerations for working with these stakeholders. The analysis can also help inform the development of materials for workshops and sensitivity trainings that are tailored to the different stakeholder audiences.

Journalists and media representatives

Working with media representatives and journalists in the country, and particularly in the region of project implementation, to inform them about key populations through sensitivity training can create an enabling environment by eliminating negative messaging about key populations and encouraging journalists to use positive or informative messages instead.

Police and other security officials

Police are integral to the protection of key populations, but they also have the power to perpetuate violence and discrimination against key populations. Security forces, such as local, regional, and national police, can be recruited to attend sensitivity trainings and workshops to create a safe and enabling environment for key populations. The IPs can also work with police to implement outreach projects in "hotspots" where police might otherwise arrest MSMs or FSWs. Ideally, the IPs might recruit "champion" police worker(s) who can assist with outreach activities, including HIV screening activities in collaboration with local police.

Photo 9: A training session with security forces in Togo. Photo Credit: PACTE-VIH (2015).

Religious leaders

Religious champions were initially recruited by the PACTE-VIH project during the landscape analysis, which helped to identify religious leaders who were already committed to advancing human rights for key populations, and who understood the need for an HIV-prevention and care program. Later, the program also worked with associations of clergies (where religious leaders across different groups gathered) in Burkina Faso and Togo to organize information sessions on HIV and key populations. Some of the attendees were so compelled by the information that they also became champions. By recruiting a project "champion" who is a part of the religious community, IPs can work to curb stigma and discrimination among religious leaders toward key populations by informing and sensitizing them about key populations.

Religious champions for PACTE-VIH acted as advocates for tolerance toward key populations within the religious community, acquired supplies and games for DICs, and assisted with the creation and distribution of advocacy materials to educate and sensitize the religious community on key populations. If possible, IPs may also consider contacting religious associations to integrate sensitization efforts (such as pamphlet distribution and sensitivity workshops) to help the project reach a wider audience of religious authorities with the goal of reducing stigma in and around the region of project implementation.

Materials needed for policy advocacy activities

- A literature review on the current policies and strategies for key populations and HIV programming in the region where the project will be implemented
- Qualitative data collected from key stakeholders to supplement the literature and determine ongoing activities related to stigma and discrimination against key populations
- An additional literature review to inform a strategy on addressing the specific areas of stigma and discrimination against key populations in that country or region
- Posters, pamphlets, and presentations on the PACTE-VIH project and on HIV and the continuum of care of key populations

3. Preparing to implement activities in support of an enabling environment

Policy assessment and landscape analysis

Assessing the political environment for key populations and for HIV programming can be achieved with a landscape analysis. After the landscape analysis, IPs can develop a summary report of opportunities, challenges, and priorities for the creation of an enabling environment.

In addition to the landscape analysis, IPs can also conduct qualitative interviews or further research on the ground to add to the evidence in the literature on the most effective way to implement a strategy for creating an enabling environment for key populations. For example, in Burkina Faso and Togo, prior to any advocacy activities, IPs conducted case studies on the treatment of key populations within the media. These case studies produced evidence of hateful speech, discrimination, and stigmatizing messages about and toward key populations from multiple media channels.

Identify key stakeholders

The IPs in Burkina Faso and Togo used the landscape analysis and needs-assessment results to identify key stakeholders for creating an enabling environment. In Burkina Faso especially, some key stakeholders, such as journalists, were recruited very slowly because of a highly hostile environment toward key populations. Other stakeholders, such as religious officials, were never integrated into sensitivity workshops or training due to a lack of compromise and a continuation of stigma and discrimination toward key populations.

Monitoring and evaluation

Database systems should be used to track indicators for the creation of an enabling environment. However, some indicators may be difficult to meet because of continued stigma and hostility toward key populations, as was the case for the IPs in Burkina Faso. The PACTE-VIH project used these indicators for the enabling environment strategy:

- Number of healthcare workers and other staff members who successfully complete an in-service training program for HIV-related service delivery
- Number of journalists trained to provide friendly and accurate reporting on PLHIV and key population

- Number of key population friendly clinic staff members who received regular supportive supervision and mentoring
- Number of peer educators who received regular supportive supervision and mentoring
- Number of annual national advocacy discussions or meetings held for key population friendly services among key actors
- Number of local advocacy groups established to advance key population programming

4. Implementing activities in support of an enabling environment: detailed description

Advocacy for policy creation and policy change

Develop an advocacy strategy

Through the needs assessment, IPs can develop a strategy to address key stakeholders in the creation of an enabling environment. In Burkina Faso and Togo, IPs held 12 workshops in addition to town hall meetings with key stakeholders — government officials, journalists and media representatives, and religious leaders — to begin the process of defining an advocacy strategy for policy change and policy creation, to organize awareness campaigns, and to develop materials to distribute during community advocacy gatherings. These "consensus-building workshops" were held in both countries and produced key materials, such as advocacy kits and activity plans. One workshop, held with journalists and media representatives, produced the *Charter for Journalists*.

(See the section on journalists and media representatives for more information on the *Charter for Journalists*.)

During the end of Year 3 in Burkina Faso and Togo, IPs recruited a consultant to work with local stakeholders and the outreach mission. The aim was to hold meetings with local civil society leaders and government stakeholders to discuss the process of accrediting NGOs that work with key populations. A document was produced through this process that verified the advocacy strategies as part of the enabling environment for each NGO. Five strategic goals were identified:

1. Reinforce MSM leadership and advocacy capacity for associations that work with MSM
2. Build a consensus among key partners and stakeholders
3. Define a strategy for advocacy
4. Build the capacity of MSM in the region to conduct advocacy for themselves
5. Hold regular advocacy meetings with members of parliament and other opinion leaders to obtain a voice for key populations in the local decision-making processes

Create advocacy materials

In Burkina Faso and Togo, IPs developed posters, pamphlets, publications, and presentations to depict data on the PACTE-VIH project in their region, as well as other data relevant to key population sensitivity and HIV programming for key populations. These materials specifically targeted the particular stakeholder audience they were trying to reach, emphasized key population issues relevant to that group (in an effort to eliminate stigma and discrimination toward key populations), and advocated programming for key populations.

(See the annex for examples of posters and publications that communicate programmatic data.)

Materials needed for the media strategy

- *The Charter of Journalists*
- Advocacy materials: pamphlets, posters, and presentation handouts
- Sensitivity training manual

Work with government stakeholders to include key populations in the national HIV policy

The Burkina Faso and Togo projects worked with MOH officials to develop a national strategy for HIV programming that incorporated key populations and gender-mainstreaming in policies, projects, and strategies for key populations. Examples of incorporating key populations into the strategy included requiring the provision of HIV services that are tailored to meet the needs of key populations, and possible interventions to target key populations.

This guide facilitated a better understanding of gender-mainstreaming to key stakeholders, and encouraged them to consider it in the formulation of national HIV/AIDS policy. A workshop to train government partners and key stakeholders on gender equity, gender-based violence, and gender mainstreaming was conducted during Year One in both projects to begin the process of integrating gender mainstreaming into future policy and legislation on HIV/AIDS and key populations.

(For an example of the national strategy, see the annex.)

Advocate for additional policy change and policy creation related to key population programming

Through the needs assessment, IPs can determine the ways that the political landscape would support or challenge the implementation of HIV programming for key populations. After this assessment, IPs can work with stakeholders to advocate national strategies and policies that directly address the health and programming needs for key populations and HIV prevention. Advocacy for policy change in Burkina Faso and Togo is ongoing, but their work so far has resulted in the implementation of key population-specific programming into the national HIV treatment guidelines.

Media Strategy

In Burkina Faso and Togo, negative or hateful messages toward or about key populations were prevalent in print and radio programming, which created a stigmatized and discriminatory environment. Because of this, the Burkina Faso and Togo PACTE-VIH project IPs recruited journalists and media representatives to attend informative sensitivity training workshops for information about key populations and how to create positive, truthful, and/or supportive messages to be disseminated through print and radio. The IPs advocated for key populations with associations for journalists (these were groups of journalists and media representatives from different organizations in that profession), which allowed a wider reach of journalists and media representatives. Through these associations, IPs recruited "champions" to reach additional journalists in the region. This process took time, and started long before the PACTE-VIH project began.

In Burkina Faso and Togo it was sometimes risky for journalists to report positive or informative messages about key populations, so IPs had to invest in relationships with journalists and gain their trust over time. Eventually, both country projects were able to recruit journalists and media representatives to deliver informative or positive messages about key populations, instead of discriminatory and negative messages. The IPs in both countries organized sensitivity workshops to engage journalists and other media representatives and steer them away from sensationalized, fear-inducing coverage that perpetuated negative stereotypes and instead encouraged accurate, positive portrayals of key populations. After the initial sensitivity workshops, IPs organized three-day refresher workshops for journalists and media representatives on an annual basis.

The IPs also collaborated with journalists and media representatives to develop a Charter of Journalists, a set of principles agreed upon by IPs and media representatives to reduce the distribution of stigmatized, sensationalized information on key populations through media channels. The Charter was made available digitally and was also distributed in print. The IPs also wrote, designed, and printed a quarterly newsletter to continue advocacy

efforts with journalists and media representatives to advocate the reduction of stigma. The IPs now hold quarterly media forums to share information on key population interventions, continue to build journalists' capacity in key population reporting, and to identify solutions to continue improving the way journalists report on key populations and depict key population issues in the media.

Empowerment

Empowerment activities can be used to encourage key populations to advocate for their own rights; key populations can also learn how to avoid and protect themselves from violence through empowerment activities. Examples of empowerment activities from the PACTE-VIH project include literacy courses, financial courses (training on how to open a bank account, how to save money, how to make a simple business plan), PE training, and advice on recognizing, avoiding, or managing violence, stigma, and discrimination through increased self-control and self-defense. Empowerment activities can be integrated into activities at DICs or implemented outside of DICs depending on the feasibility and the needs of the key populations participating in the activities.

5. Challenges and facilitating factors for creating an enabling environment

Challenges

The IPs may encounter some of the following challenges while planning and implementing an enabling environment strategy. These issues should be considered in the project's work plan and budget to prevent unnecessary roadblocks and challenges.

Lack of funding

Limited funding can prevent the immediate development of the tools needed for advocacy, and prevent strategy development because the personnel or the man-hours are not available. Funding issues for the enabling environment strategy can be avoided by budgeting for enabling environment activities and materials during the project's design phase.

Stigma and discrimination

The society may be highly discriminatory toward key populations, and enabling environment activities will be particularly difficult to implement in a hostile environment. For example, religious leaders in Burkina Faso were openly discriminatory toward key populations and perpetuated stigma in the country, and journalists facilitated harassment through sensationalized or false messaging in various media outlets. Such a highly stigmatized environment made it difficult to implement changes in programming and advocacy efforts for MSM. For FSWs, police harassment was also common in Burkina Faso and Togo, and made it difficult to recruit police officials.

Reluctance among media representatives and journalists

Journalists may be reluctant to participate in sensitization workshops or projects because of stigma or the belief they would be asked to advertise homosexual behavior if they attend these workshops. The IPs can inform journalists about the true nature of sensitization training (to encourage accurate reporting of information about key populations), which may increase the journalists' willingness to attend trainings and workshops — as was the case in Burkina Faso and Togo.

Facilitating factors

The following considerations helped IPs successfully implement the enabling environment strategy in Burkina Faso and Togo. These factors can provide guidance on how to leverage key strategies for a successful implementation.

National strategy development

The national strategy document was a key element for developing an enabling environment for the PACTE-VIH projects in Burkina Faso and Togo. The document was created in collaboration with community stakeholders — including government officials — and IPs to leverage existing policies in conjunction with new strategies for reaching key populations and reducing stigma and discrimination in programming for key populations. This document served as a reference point for the advocacy activities toward policy change and targeted programming for key populations. The IPs and the core-project management staff who are replicating PACTE-VIH can also use a similar method of leveraging a national strategy to help create an enabling environment.

(See the annex for an example of the national strategy document.)

The Charter of Journalists

The Charter of Journalists was created by IPs in collaboration with journalists and media representatives to eliminate embellishment, stigma, and discriminatory messages about key populations in the media. The Charter was an agreement of journalists on the principles of reporting regarding messages about key populations in the future — an agreement not to spread homophobic messages in the media.

(See the annex for an example of *The Charter*.)

Advocacy strategy development

A needs assessment will help IPs to develop an advocacy strategy to reach key stakeholders. The IPs can hold strategic planning workshops with advocates, PEs, and key stakeholders to define an advocacy strategy and to validate activities that would expand key population programming and reduce stigma and discrimination against key populations. These "consensus-building workshops" can be used to produce key materials, such as advocacy kits and activity plans.

Cooperation from key stakeholders

Although it did take time and an effective strategy, many key stakeholders did invest in the enabling environment activities in the PACTE-VIH project in both countries, including journalists and media representatives (both countries), religious leaders (Togo), government leaders (both countries), and police and security authorities (Togo).

6. Considerations for replicating activities in support of an enabling environment

These four items (see box below) are absolutely critical for ensuring successful implementation of the enabling environment strategy. The list includes essential factors to anticipate and overcome, and potential adaptations to adopt when replicating the enabling environment strategy.

1. Collect the necessary information to tailor strategies for supporting an enabling environment
2. Ensure adequate resources
3. Develop strategies and materials for advocacy in collaboration with key stakeholders
4. Establish government buy-in

Collect the necessary information to tailor strategies for supporting an enabling environment

The landscape analysis will determine the capacity of existing clinics and facilities, the identity of the key stakeholders, and the gaps in programming and policy that need to be addressed to create an enabling environment. Once the landscape analysis is complete, the results can be used to strategize for advocacy and determine which key stakeholders to work with to have the greatest impact in creating an enabling environment for key populations.

Group photograph of PACTE-VIH staff, partners and participants at the 2nd Regional KP Meeting – Togo. Photo Credit: PACTE-VIH (2015).

Ensure adequate resources

During the project planning phase, IPs should plan and budget for adequate resources, including staffing hours, to develop key relationships with stakeholders through consistent and long-term efforts. For example, in Burkina Faso, it took years to establish relationships with media representatives. These established relationships created opportunities to engage journalists and media representatives in key population advocacy efforts.

Develop strategies and materials for advocacy in collaboration with key stakeholders

Through workshops with key stakeholders, IPs can develop an advocacy strategy and define activities to expand key population programming and reduce stigma and discrimination against key populations. For example, the national strategy for HIV prevention was improved through advocacy work in Burkina Faso and Togo, and then used as a reference point for future advocacy strategies.

When replicating the enabling environment strategy, it is essential to work with media representatives to ensure the messages being delivered about key populations to the general public are accurate and positive, and that they do not foster a stigmatized environment. In Burkina Faso and Togo, The Charter of Journalists was developed by IPs in collaboration with journalists and media representatives and represented the principles of responsible information gathering and processing to reduce stigmatized, sensationalized reporting on key populations through various media channels. The Charter was designed digitally and was also distributed in print. The IPs also wrote, designed, and printed a quarterly newsletter to continue advocacy efforts with journalists and media representatives to advocate for the reduction of stigma.

ANNEX

- SBCC materials:
  https://drive.google.com/file/d/0B-mBPqdLrO_Na3FKVWZBMjJha0U/view?pref=2&pli=1
- Clinic capacity evaluation tool:
  https://drive.google.com/file/d/0B-mBPqdLrO_NTFVzSmIxR215b0U/view?pref=2&pli=1
- List of indicators to use for testing the effectiveness of the PE training:
  https://drive.google.com/file/d/0B-mBPqdLrO_NbUxERVVOdGdRWm8/view?pref=2&pli=1
- Data tracking sheet for clinics:
  https://drive.google.com/file/d/0B-mBPqdLrO_NYzdHTEFOUVlicUk/view?pref=2&pli=1
- Manual of procedures and processes for PACTE-VIH:
  https://drive.google.com/file/d/0B-mBPqdLrO_NZXk2RUtZTTBibmM/view?pref=2&pli=1
- Mapping Matrix for peer educators:
  https://drive.google.com/file/d/0B-mBPqdLrO_NZUJZV0g3blE5c2s/view?pref=2&pli=1
- The Kenya HIV/AIDS National Strategic Plan: 2016-2020:
  https://drive.google.com/file/d/0B-mBPqdLrO_NdFl0SFNXOFAzWjQ/view?pref=2&pli=1
- PE training manual:
  https://drive.google.com/file/d/0B-mBPqdLrO_NQk5NdHFsNGtBTU0/view?pref=2&pli=1
- Poster example for the mHealth strategy:
  https://drive.google.com/file/d/0B-mBPqdLrO_NYm9nRDFkMklEQ2M/view?pref=2&pli=1
- Publication example for the mHealth strategy:
  https://drive.google.com/file/d/0B-mBPqdLrO_NclNjdUlSSjNDUDA/view?pref=2&pli=1
- Project timeline example:
  https://drive.google.com/file/d/0B-mBPqdLrO_NZUJaT3pGczI0dkk/view?pref=2&pli=1
- Referral coupon template:
  https://drive.google.com/file/d/0B-mBPqdLrO_NaWFBZVdWNllEdDQ/view?pref=2&pli=1
- Sensitivity training guide for key stakeholders:
  https://drive.google.com/file/d/0B-mBPqdLrO_NdHhWV0lfOVFiOVE/view?pref=2&pli=1
- The Charter of Journalists:
  https://drive.google.com/file/d/0B-mBPqdLrO_NS0ZzV3M0WkMzalk/view?pref=2&pli=1

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