

# TOWARDS PEER-LED HIV AND SRH SERVICES

## for Sex Workers and Men Having Sex with Men

Experience from Médecins sans Frontières in Malawi and Mozambique



# EXCLUDED FROM HEALTHCARE

Globally 20.9 million people are receiving ART, with several countries on track to reach the 90-90-90 targets by 2020. Despite this progress, certain populations are being left behind. **Key populations (KP), including men who have sex with men (MSM), sex workers (SW), transgender people (TG), people who inject drugs (PWID), and prisoners struggle to access medical services, while data shows that in most countries these groups have a higher risk of contracting HIV.** Globally HIV prevalence among female SWs and MSM is 12 and 19 times higher respectively than in the general population<sup>1</sup>. 80% of new HIV infections outside of sub-Saharan Africa occur among KP and their sexual partners. In high prevalence countries in sub-Saharan Africa, 25% of new infections occur amongst this group<sup>2</sup>.


KP are often isolated and criminalized; subjected to social rejection, stigma, discrimination, and violence. Too often, despite their high risk of acquiring HIV and the need to access healthcare they are effectively excluded from government health services. Once on treatment, increased mobility and structural violence create challenging circumstances for them to remain in effective care.

To reach KP, HIV services and the medical package for each specific population must be adapted to their needs. MSF has been collaborating with the Ministry of Health (MoH) and partners in Malawi and Mozambique since 2009 supporting the implementation of client-centred models of differentiated service delivery.

*This briefing document aims to share the experience of MSF programmes adapting their services to the needs of SW and MSM*



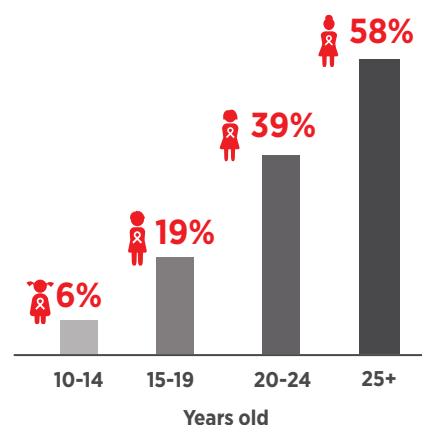
MSF health care worker Sebastiana Cumbe provides HIV testing services (HTS) in Beira, Mozambique © Felco Calderin

 **Extraordinarily high risk of acquiring HIV**

**In Nsanje, Malawi** the prevalence of HIV among female sex workers (FSW) attending the MSF clinic ranged from **6% in young FSW aged 10-14, to 58% in those older than 25 years** (Fig 1). Most SW begin sex work as adolescents and young adults. In Nsanje, a specific time has been allocated for a clinic for adolescent SW. In Beira a study among MSM showed that HIV prevalence rose from **2.8% at age 18-24 to 32.1% among those more than 24 years**<sup>3</sup>.

*in Malawi and Mozambique. Over 9000 SW since 2013 and 330 MSM since 2016 have been enrolled in these projects. The development of services has been guided by WHO recommendations on KP<sup>4</sup>. In addition to adapting how HIV testing and treatment is delivered, an adapted comprehensive medical package including PrEP has been integrated into these services. The case studies described in this document illustrate the options available for the delivery of peer-led, patient-centred HIV and SRH services for SW and MSM.*

**Figure 1. HIV prevalence among Female Sex Workers in Nsanje, Malawi**



1 Global AIDS response progress report 2014. Geneva: Joint United Nations Programme on HIV/AIDS; 2014 (<http://www.aidsinfoonline.org>)

2 UNAIDS. Ending AIDS: Progress towards 90-90-90 targets. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS);2017

3 Men Who Have Sex with Men in Mozambique: Identifying a Hidden Population at High-risk for HIV. Nalá, R., Cummings, B., Horth, R. et al. AIDS Behav (2015) 19: 393. <https://doi.org/10.1007/s10461-014-0895-8>

4 World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations –2016 update. Geneva: WHO;2016.

# MOVING TOWARDS INCLUSION

In the design of healthcare services for SW and MSM, each MSF project highlights the importance of the following principles:

## Peer-led service delivery

Access and delivery of care to excluded populations is critically dependent on a trained, paid, peer cadre working with sensitized healthcare workers.

## Providing 'One-Stop' services

A package of care including HIV and SRH services should be provided at the same site, on the same day, ideally by the same healthcare worker. Each additional venue a SW or MSM must visit to access all their health needs represents an additional barrier.

## Strategic mix of MoH and NGO/CBO services

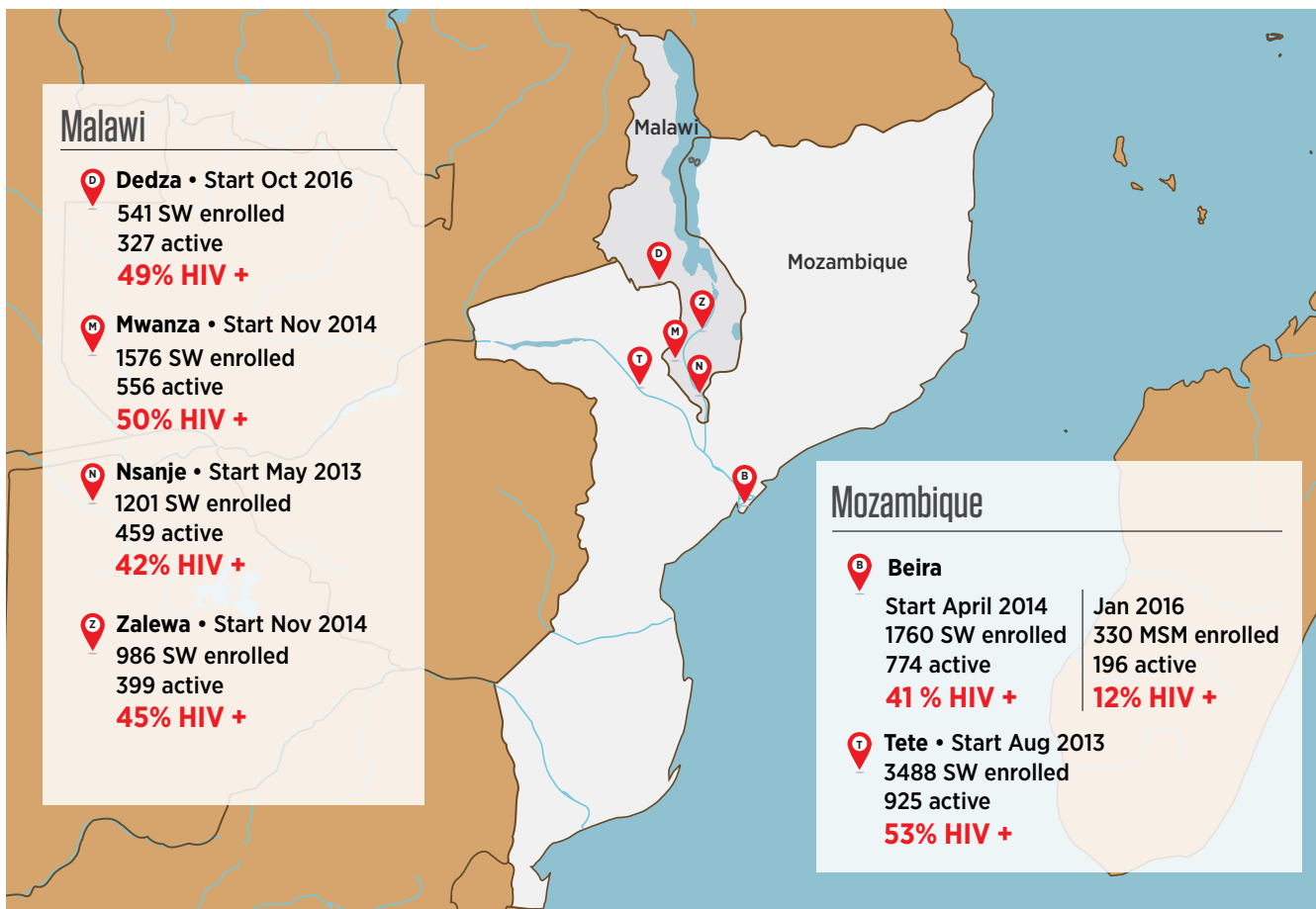
Provision of 'friendly' MoH-led services where SW and MSM can access care along with the general population is essential. However such friendly services are often far from the reality. While moving towards integration into MoH services, fully-funded, community-based services specifically for SW and MSM, which are run in parallel with MoH services, are essential. The sustainability of such services is a major challenge.

## Advocacy and activism to enable sustainable access

The creation of an enabling environment for equitable access to healthcare for SW and MSM is an essential component of effective programming. This entails support to local CSOs in challenging criminalisation of these populations and societal efforts to change attitudes as well as capacity-building to empower MoH staff and partners to develop friendly and sustainable services.

## Map of MSF SW and MSM Projects in Mozambique and Malawi

In Malawi and Mozambique, six MSF project sites offer adapted peer led HIV and SRH services to SW and MSM groups following principles outlined in this report.





# WHO PROVIDES SERVICES?

## Peer-led service delivery for SW in Tete, Mozambique

In Tete, Mozambique there is a high density of sex workers attracted by the booming coal mining industry, as well as the city being a major transport corridor for long distance lorry drivers. Mozambican and foreign (mostly Zimbabwean and Malawian) sex workers gather at hot spots. Some work openly while others are more hidden. Overcrowded and underfunded local health facilities have difficulty responding to the needs of mobile populations and particularly for highly stigmatised and discriminated groups such as SW.

To engage with this population, peer SW from the main hot spots were employed and trained to work with MSF as educators and to mobilise SW to attend scheduled mobile clinic visits. Peers provide health education, distribute condoms and lubricants, and support navigation to health services and tracing. In most sites SW had already developed informal groups supporting each other for security and financially. These groups interact with and facilitate formal peer SW activities.

Services provided by nurses and counsellors in the mobile clinics include HIV, hepatitis B and syphilis testing, viral load (VL) and CD4 monitoring, TB and STI screening and treatment, and contraceptive provision. Health education and counselling are offered to individuals or groups. Those testing positive for HIV are referred or navigated to the local health facilities by peer educators. Mobile services are provided by MSF, sometimes accompanied by MoH staff, whilst ART is provided in an MoH ART clinic.

An existing model of ART delivery, the community ART groups, was adapted to form sex worker ART groups. However in this context uptake of this model was low due to competition and fear of disclosure between the sex workers. The mobility of this population is another major challenge, with many moving frequently between Mozambique, Malawi and Zimbabwe. To



MSF peer educator Cecilia Khanje accompanies a client in the streets of Zalewa, Malawi © Aurelie Baumel/MSF

***“I really love the job I am doing with MSF to help my friends who are sex workers. They are very open in sharing their problems with me!”***

*A peer educator in Nsanje describes her role in overcoming barriers to care for SW*

address this, the ART refill duration is adapted by the healthcare worker to ensure the SW or MSM client has a continued supply during the period of travel.

### Peer-led service delivery

For both SW and MSM groups, the engagement of peers in providing care has been essential. In MSF projects peers have been engaged across the HIV cascade (Fig 2) and play an important role as activists and advocates. Ongoing capacity building is important to ensure that messages are owned and passed within SW and MSM communities.

Peer SW and MSM are selected from the local community based on their motivation, ability, and knowledge of the vulnerabilities faced by the target group. Peers receive a three to five day training and spend time shadowing counsellors and nurses providing comprehensive HIV and SRH services.

Peer SW and MSM mainly work outside of traditional clinic working hours in order to reach their target populations. They meet weekly with the multidisciplinary healthcare teams to discuss challenges.

Working with peers also brings challenges. Efforts are needed to ensure respect and acceptance from healthworkers who are not themselves from KP. There may be conflicts and mistrust within the peer-group. In addition continuous mentorship and support is needed to ensure the quality of messaging and services.

***“they don’t realize it, but the reason we work here, is for them to be able to do their work”***

*MSF peer educator describing a lack of acknowledgement by her non-peer healthworker colleagues in the SW project*

Figure 2: Engaging SW and MSM peers across the HIV cascade

HIV Testing	HIV Prevention	HIV Treatment	Retention and virological suppression
Reaching and mobilising peer group clients to be tested	Mobilising and linking HIV negative clients to prevention services	Linking and/or navigating HIV-positive clients to ART services	Tracing clients on ART lost to follow up
Supporting HIV testing	Providing condoms, lubricants and health education	Adapted ART delivery within ART group and other models	Treatment literacy and addressing stigma and discrimination
	Tracing clients on PrEP who are lost to follow up		Ensuring clients viral load is done and results understood

### What is a KP "friendly" service?

To be 'friendly', a service requires staff who welcome and do not stigmatise or mistreat SW and MSM, and services and times that are adapted to their needs. Adaptation may also be needed for subgroups such as adolescents. Staff need to be trained appropriately to be comfortable and non-judgemental in discussing issues related to sexuality and sexual behaviour. Similar efforts are needed to sensitise police to provide support and protection for sex workers. MSF teams with peer representation engage in sensitisation workshops with both health centre staff and police.



Farisai Gamariel (right) supervises MSF's services for Men who have Sex with Men (MSM) in Beira, Mozambique © Sanna Gustafsson/MSF

***"I invite new MSM when I go to the bars, but we had to think of different ways, and social media networks seem to be good for this"***

*Farisai Gamariel on the complex task of reaching MSM clients in Beira, Mozambique*



## WHEN ARE SERVICES PROVIDED?

### Adapted times for service delivery for SW in Mwanza, Dedza and Zalewa, Malawi

**In Mwanza, and the nearby sites of Dedza and Zalewa,** HIV testing is offered by lay workers through door to door and hot spot outreach. Peers mobilise their community around the benefits of HIV testing and provide information as to when and where testing services will be provided in the community. A lay counsellor and the peer SW attend the identified and scheduled sites, such as bottle stores or bars with booking rooms, or in homesteads.

Peers ensure SW are linked to services at the local health facility, where MSF supports and promotes integrated comprehensive HIV and SRH services, including VL monitoring and diagnostics for TB with GeneXpert, in collaboration with the MoH. MSF also provides SGBV support. These services are open every day but work schedules and availability mean most SW are seen after mid-morning. Adolescent SW can attend specific 'Teen Clubs' for adapted services.

Timing of testing and ART services should be adapted to the clients' preference in both clinics and outreach services. The frequency of visits should be the same as for clients from the general population and ART refills of three to six months should be provided. Long refills are particularly important for SW who are often highly mobile. Advocacy to endorse provision of longer ART refills for mobile populations within national policy should also be supported.



# WHAT SERVICES ARE PROVIDED?

## Providing ART and an adapted medical package in Beira, Mozambique

**The port city of Beira has a high density of national and foreign SW.** MSF has been supporting provision of SW services since 2014 and MSM services since 2016 <sup>5</sup>. Engagement with the MSM population is facilitated by LAMBDA, a national community-based organisation working for the empowerment and rights of LGBTI groups.

Trained peer SW and MSM are allocated to catchment areas, reaching and following up on a maximum of 60 beneficiaries each. They provide health talks to mobilise and navigate beneficiaries through the existing health facilities. Only the minimum package of care can be accessed on outreach whilst the full comprehensive package is provided at the health facility (see Table 1). Sites aim to provide services opportunistically, whenever a SW or MSM presents for care, as many clients, for reasons of stigma or mobility may not return. Where possible point-of-care diagnostics are used. It was found that while

peer outreach enabled access for SW it was less successful with MSM who were often more fearful of disclosure. Mobile phone-based and other social media approaches, such as Whatsapp groups were more effective.

Safe space empowerment activities are planned with the team, mobilised by peers, and conducted at specific ‘drop-in’ sites offering safe and confidential environments. These are opportunities to promote dialogue and mutual support to build cohesion as well as to enhance health and treatment literacy. A local SW theatre group further builds this dialogue in community sites and health facilities with MSF support.

Depending on the model of care provision and the healthcare provider available, there should be a clearly defined package of medical services provided at each site. MSF has applied a minimum and comprehensive package depending on the feasibility of providing the care.

*“ Now, I’m relaxed! Ah! Now I am a soldier with a gun – I’m in battle. I am protected ”.*

*A Zimbabwean SW explains her reasons for taking PrEP*

### High demand for PrEP among SW and MSM in Beira Mozambique

Between March 2016 and December 2017 252 FSW and 58 MSM were offered PrEP. 119 FSW and 42 MSM were enrolled on PrEP. Preliminary results show retention rates at one, six, and twelve months on PrEP were 73%, 40% and 25% respectively. To date only one seroconversion has occurred.

### The Data challenge

Reliable information on provision of healthcare services for KP is difficult to obtain. Stigma and criminalisation prevents many SW from identifying openly, particularly in MoH health facilities. Fragmentation of services between MoH and parallel facilities adds to the challenge. Community-level monitoring and evaluation (M&E) and the follow-up of HIV negative high-risk cohorts is complex and rarely routine. Fears of how such data may be used in settings where these populations are criminalized may also contribute as a barrier for improved data collection.

While peer SW can help at community level, integration at facility level remains a challenge. In principle HIV testing, viral load, and CD4 results could all be collected alongside cohort retention data for KP in the community.

**Table 1: Packages of HIV and SRH care for SW and MSM**

Minimum package	Comprehensive Medical Package
HIV testing services (and HIV self-testing in future)	Minimum package plus:
Provision of condoms and lubricants	PrEP
PEP and emergency contraception	TOP
STI screening and treatment	HPV vaccination and cervical cancer screening
TB screening	ART services (including viral load, CD4 and both first- and second-line ART)
Contraceptive services	TB, cryptococcal meningitis and other opportunistic infection (OI) diagnosis and treatment
Referral for ANC, TOP, cervical cancer screening and ART	Hepatitis B screening and vaccination
Safe space activities	Hepatitis C screening for MSM

<sup>5</sup> An article describing SW and MSM experiences in Beira can be found at <https://thewire.in/gender/the-sex-workers-who-are-stopping-hiv>.



# WHERE ARE SERVICES PROVIDED?

## Providing HIV and adapted medical services for SW in Nsanje, Malawi

In Nsanje, Malawi, two options for accessing services were developed, influenced by the need to integrate with the MoH in order to plan for sustainable services. In one area of Nsanje town with a high density of SW, a weekly SW-focused service was added in the MoH ART clinic at Nsanje district hospital at an adapted time (11 am till 2 pm). The clinic is coordinated by MoH nurses who provide ART, with tailored integrated STI screening and SRH services, including contraception, with support from MSF nurses. MSF peer educators welcome returning and new clients and provide health education and support. Counselling related to HIV care is provided by MoH and MSF counsellors.

In a second hot spot, a mobile clinic was established due to the difficulty of integrating services into the local catholic mission hospital. The clinic is held in a community site, with two rooms used for consultation. The mobile team brings furniture to adapt two rooms for clinical or counselling consultations, whilst the third room is used for safe space activities and health education.

To mobilise SW to attend this mobile site, peer educators run outreach education and raise awareness about the mobile clinic visit dates each month. The mobile clinic is staffed by two nurses and two counsellors provided from MoH and MSF as well as local peer educators. A one-stop service provides the minimum package as well as ART initiation and follow up and referral for comprehensive services. These services were further adapted by designating a specific time for adolescent and young SW to answer to their specific needs which might otherwise be hindered by the presence of older SW.

In both these models MSF and MoH staff were provided with specific training and sensitization to provide friendly, tailored HIV and health services for SW. Feedback has demonstrated high levels of satisfaction from SW, but ongoing sensitization of MoH staff is challenging particularly where staff turnover is high. In periods where a clear “champion” amongst nurses is identified, the success of such programmes, both from a medical and acceptability perspective, is greatly increased.

**The choice of ‘where’ to provide services for SW should be decided after participatory consultation and mapping with both clients and healthcare workers. Options include:**

- **Mobile outreach clinic in community hot spots** or sites selected seasonally, run by an NGO or private provider alone or with the MoH
- **Standalone/parallel fixed site clinics** run by an NGO or private provider
- **Existing MoH ART or SRH clinic** with sensitized staff for SW or MSM

### Challenges in delivery of ‘One-Stop’ services

While ideally all commonly required services should be available in the minimum package, in reality this is difficult to achieve in private or CBO services. Trained peer and other community cadres are not always permitted to provide HIV testing, take blood samples, or to initiate and monitor ART. This *de facto* excludes such services from non-MoH sites, which may in turn exclude KP from access. Efforts are needed to ensure accreditation of parallel sites for ART and other relevant laboratory and treatment services. Similarly MoH sites should integrate the comprehensive package of services needed by KP.



MSF outreach team conducts a needs assessment and a health education session in Tete, Mozambique  
© Lucy O’Connell/MSF

# SCALABLE OR DOOMED?

The MSF programmes described have all been established in collaboration with the MoH and although the projects are focused on SW and MSM, many of the lessons learnt and models adapted may be applied to programming for other key populations, and hard-to-reach groups such as migrants and adolescents. However, small as these projects are, without another implementing partner and international funding the continuity of these services is threatened.

Reaching the most at risk has a cost, in particular when providing outreach and mobile services which require additional resources for peer cadre salaries and transport costs. The vast majority of KP-focused services are provided through PEPFAR or GFATM-funded initiatives whose reach and sustainability are not assured.

As HIV funding declines, as the GFATM withdraws from middle income settings, and as PEPFAR funding is denied to SRH and KP focused initiatives which support womens' access to contraception and safe abortion, it will become harder to maintain investment in these services.

Is it possible to take such models to scale? Is it realistic to expect MoH to ensure service delivery models for SW and MSM, both within government settings and in parallel services? Even where demonstrably cost-efficient, it is a political hard sell to invest in services for KP, even more so where they are criminalized.

Nonetheless there are many healthworkers, politicians and activists committed to ensuring that these services exist, even where they must operate on the edge of the law. There are examples where KP programming has been integrated into MoH service delivery policy - for example in Zimbabwe, South Africa, Ghana and Tanzania - but the ability of ministries and partners to support implementation is heavily dependent on unpredictable donor funding and changing political landscapes.

MSF's experience of providing SW and MSM services has demonstrated that care can be delivered in a collaborative way with MoH and civil society. Still, more needs to be done. Integrated health services adapted for KP needs must be fully funded and scaled up if the UN stated ambition to 'leave no one behind' is to be more than just a slogan.



Night falls in the port town of Beira, Mozambique, along the transport corridor linking Malawi, Zambia and Zimbabwe  
© Gianluigi Guercia/AFP

## The Way Forward

### Increased international and domestic funding for KP programming ;

- targetted international funding in high and middle-income countries must continue where national governments refuse to meet KP needs
- specific funding and technical support for initiatives aimed at empowering and addressing the needs of KP including investment in KP community networks, civil society capacity-building and the creation of a community of practice

### Inclusion of key population programming at all levels;

- within national clinical and service delivery guidance and health service budgets
- provision of a comprehensive integrated package of care with HIV prevention and care services including long ART refills, TB and OI diagnosis and treatment, SRH services including safe abortion care and long-acting contraceptive choices and access to PrEP
- specific inclusion of a mix of friendly MoH integrated services and parallel community-based alternatives
- funding, accreditation and formalisation of training, and continuing education, for KP peer cadres

### Greater investment in research and advocacy

- research to demonstrate the impact and cost-efficiency of service delivery models for KP
- advocacy and activism to address violence, criminalization, stigma and denial of access to healthcare services

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