Welcome to the SSLN Link & Learn on

Integrated Service Delivery Models for Key Populations

Hosted by Eswatini & Zimbabwe

26 April 2023

We're curious to know who are here - in the chat, **say *hi* and let us know where you are from**!

In the *participants* tab, ***raise your hand* if you'd like to speak during the discussion**

BILL & MELINDA GATES foundation

AGENDA: Service Delivery Models for Key Populations

SESSIONS	FACILITATORS / SPEAKERS	DURATION
1 **Opening & Welcome**	Zandile Masangane Adolescent Sexual Reproductive Health Technical Lead Ministry of Health Dr. Bongani Zakhele Masango National HIV Prevention Coordinator Eswatini National Aids Program	15 minutes
2 **Mentimeter** | What important learning would you like to leave this session with?	Zandile Masangane Adolescent Sexual Reproductive Health Technical Lead Ministry of Health Dr. Bongani Zakhele Masango National HIV Prevention Coordinator Eswatini National Aids Program	10 minutes
3 **Zimbabwe** | Lessons Learnt implementing Integrated KP focused HIV/SRHR programs in Zimbabwe	Humphrey Ndondo Senior Technical Specialist Key Populations National AIDS Council, Zimbabwe	20 minutes
4 **Eswatini** | Service Delivery Models for Key Populations in Eswatini	Sindy Matse Acting Program Manager Eswatini National AIDS Programme	20 minutes
5 **Discussion and Q&A**	Zandile Masangane Dr. Bongani Zakhele Masango Humphrey Ndondo	30 minutes
6 **Key takeaways | South Africa & Ghana**	South Africa & Ghana champions	20 minutes

Opening & Welcome

Zandile Masangane

Adolescent Sexual Reproductive Health Technical Lead
Ministry of Health

Dr. Bongani Zakhele Masango

National HIV Prevention Coordinator
Eswatini National Aids Program

Mentimeter:

What important learning would you like to leave this session with?

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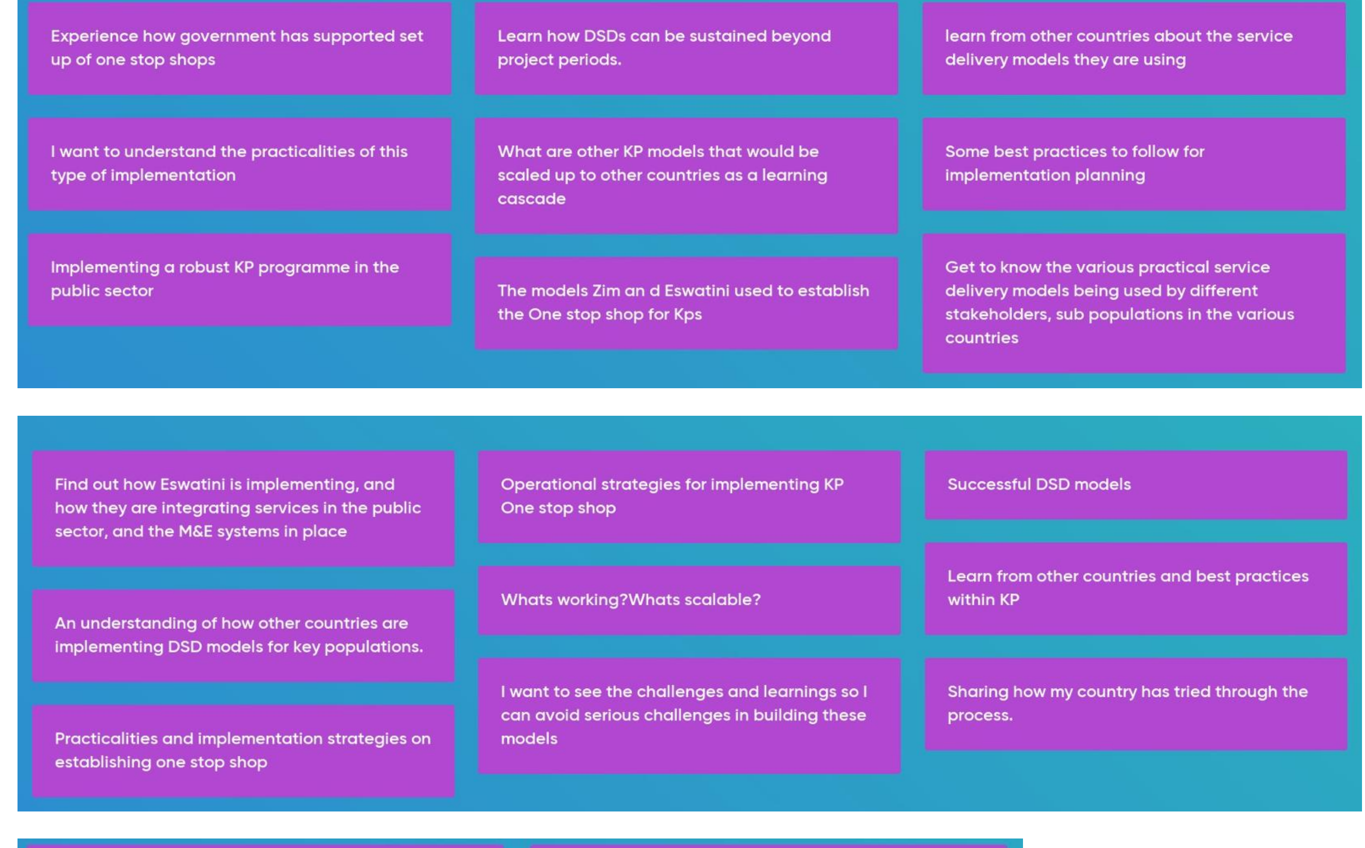
Mentimeter responses:

What important learning would you like to leave this session with?



Lessons Learnt implementing Integrated KP focused HIV/SRHR programs in Zimbabwe

Humphrey Ndondo

Senior Technical Advisor- Key Populations

National AIDS Council, Zimbabwe

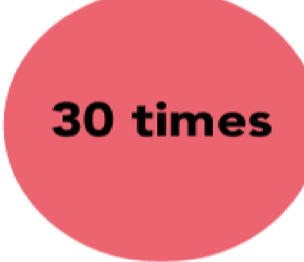
Presentation Outline

- Introduction
- Progress towards the 95-95-95 UNAIDS Fast Track targets
- Person Centred Integration and Inclusion of Key Populations
- Zimbabwe HIV/SRHR Service Delivery Model for Key Populations
- Strategies for implementing KP Differentiated Service Delivery Programmes
- integrating HIV Prevention and Harm Reduction DSD models for PWUID
- Example- Integrated KP DSD for MSM, the ColourZ intervention
- Barriers to implementing integrated HIV/SRHR intervention
- Conclusion

Introduction

Whilst key populations constitute a small proportion of the general population globally, in 2021, **70% of all new infections were from key populations** (sex workers, men who have sex with men, transgender people, people who inject drugs, prisoners) and their partners (UNAIDS, 2021). However, key populations have less access to HIV prevention and treatment services. To enhance progress towards achieving HIV epidemic control and attainment of the Sustainable Development Goals, it is critical that key populations have increased access to integrated HIV prevention services.

People who inject drugs have 35 times greater risk of acquiring HIV than adults who do not inject drugs



Female sex workers have 30 times greater risk of acquiring HIV than adult women (15-49) in the general population

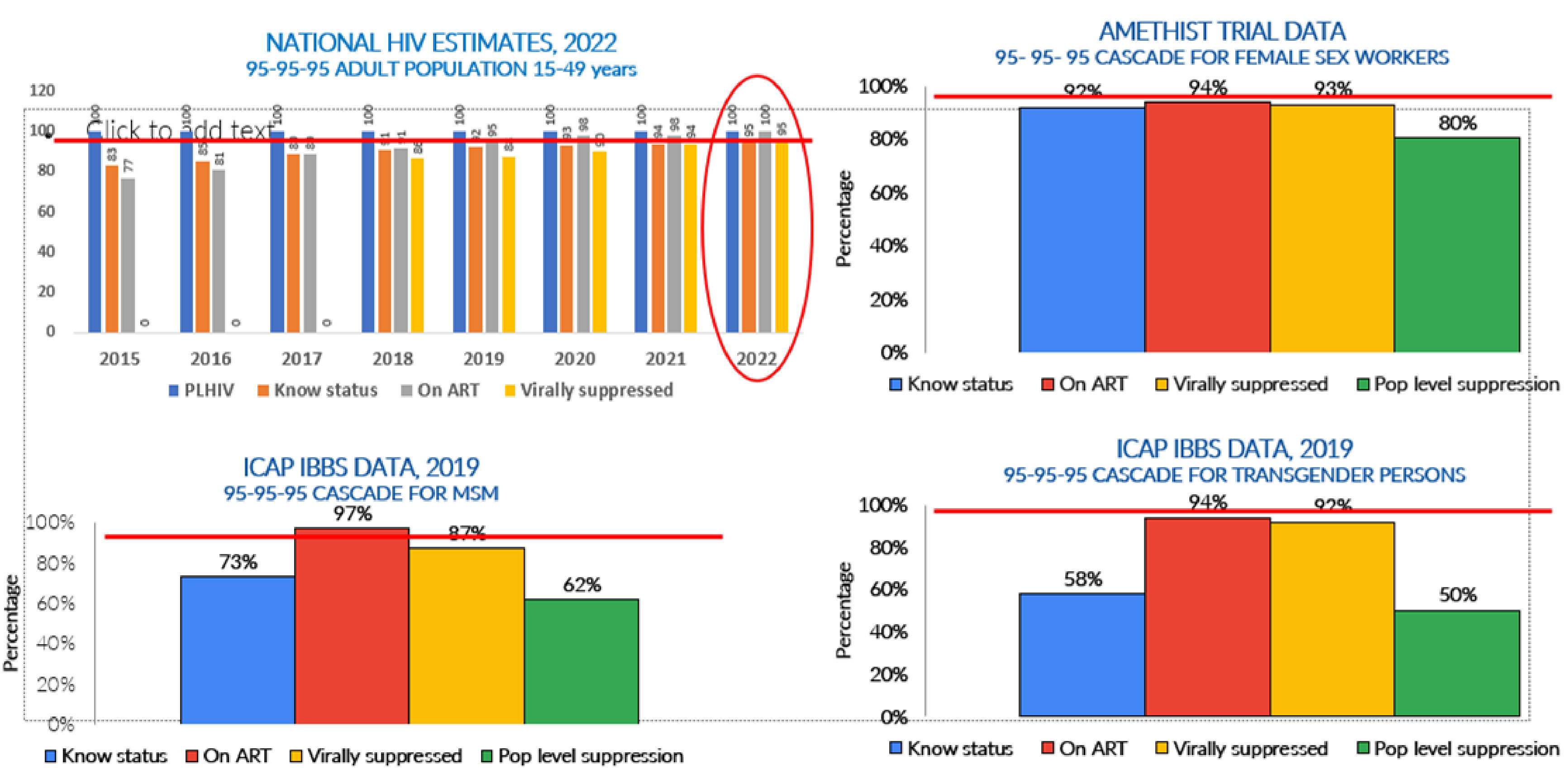
Gay men and other men who have sex with men have 28 times greater risk of acquiring HIV than adult men (15-49) in the general population

Transgender women have 14 times greater risk of acquiring HIV than adult women (15-49) in the general population

Source: UNAIDS special analysis, 2022 (see Annex on Methods).

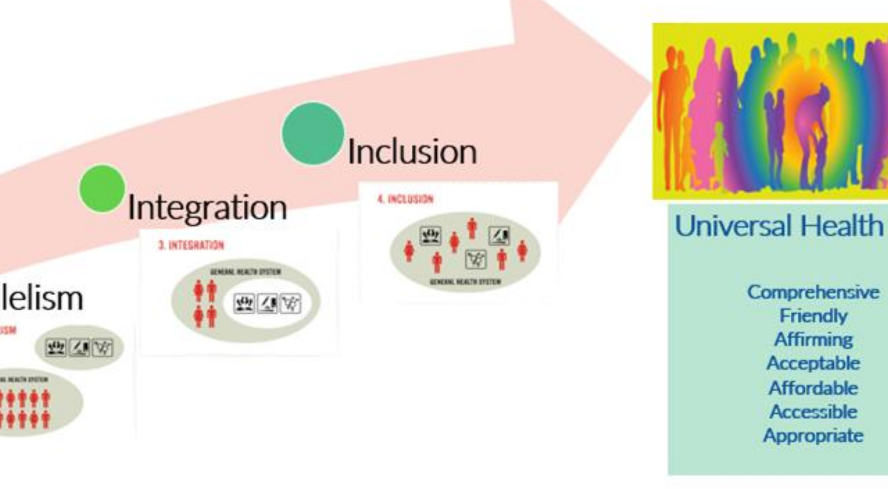
- Imprecise and Gaps in Data
- Inadequate KP program scale
- Restrictive policy and legal environment
- Stigma and Discrimination
- Heterogeneous Needs of the Communities

KP Progress towards 95-95-95



Meaningful engagement of KPs: Integration and Inclusion

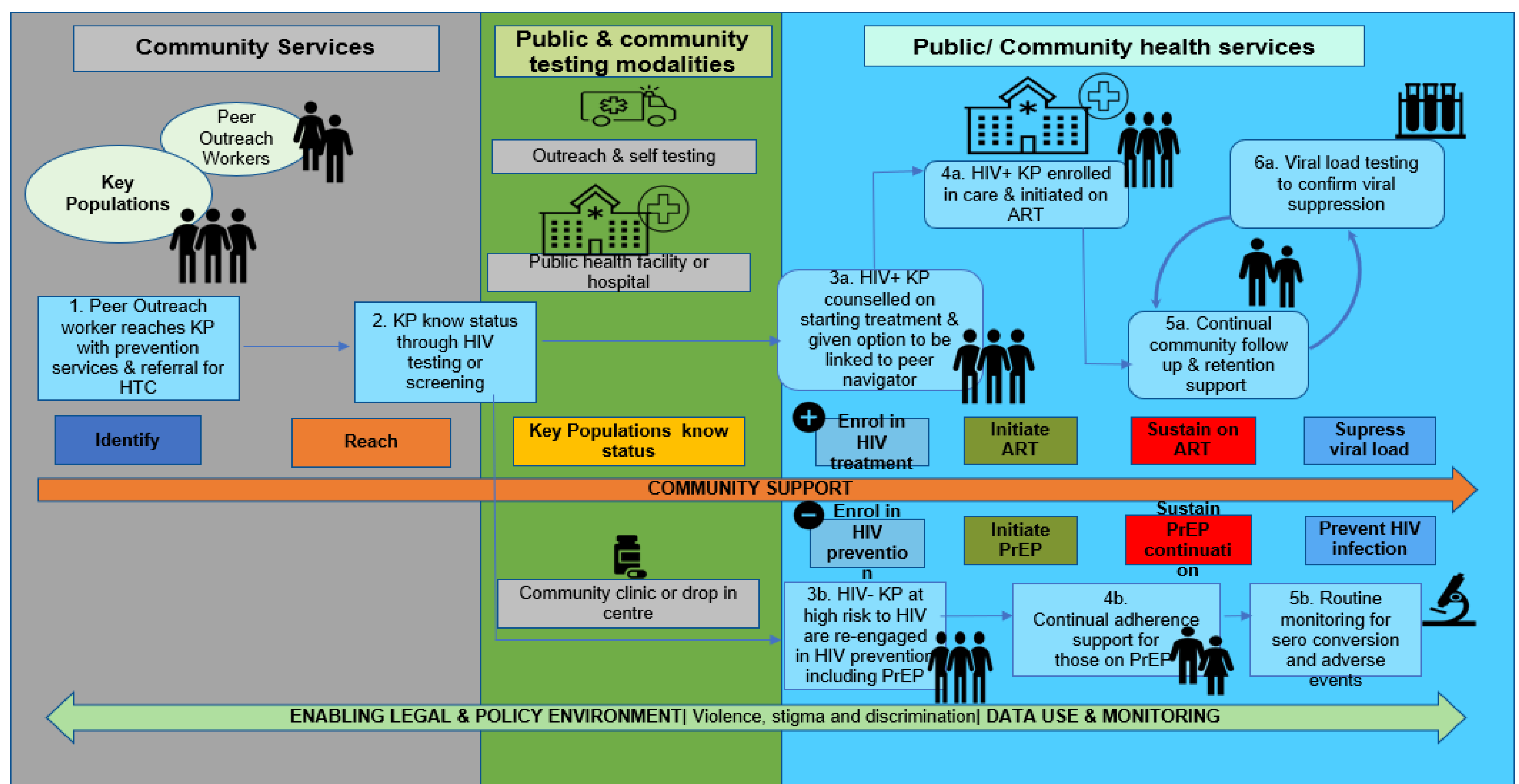
Integration: ''the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.'' WHO 2017



- HCD driven approaches to better understand the heterogenous needs of KPs
- Differentiated Service Delivery tailored to meet specific needs e.g ColourZ Initiative
- Capacity building of health care workers to provide comprehensive, friendly and affirming care

- Engaging KP communities in the design, implementation, monitoring and evaluation of HIV/SRHR services
- Community led monitoring to strengthen the community feedback loop on the quality of Integrated HIV services delivery for KPs
  - HTS, PrEP, ART, IPV, Mental Health, SRHR (including contraception, cervical cancer screening, STI)

Zimbabwe HIV/SRH service delivery model for KPs



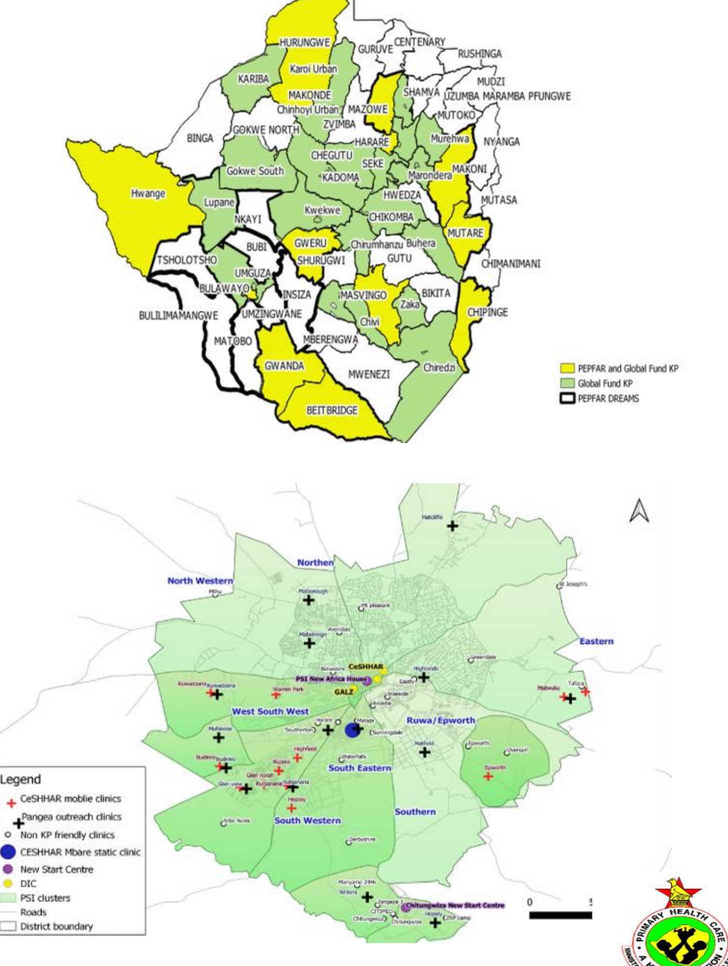
Strategies for implementing integrated KP Differentiated Service Delivery Programs

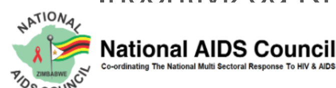
Hub and spoke model:

- Static facilities (Gvt, Centres of Excellence, DICs) operate as hubs with variable outreach points radiating from each hub into the Community

Differentiated, decentralized service delivery approach:

- Multi-disciplinary teams in distinct geographical clusters
- Differentiated and Disaggregated for SWs and their clients, MSM, TG
- Service Integration, task sharing/shifting, self-care
- Layering of HIV prevention care and treatment services with SRH, STI
- Peer led demand creation and retention support through KP peers and KP Health Assistants
- Incentivized KP peers to mobilize and navigate





Human centred design approaches to improve KP differentiated service delivery

Routine interrogation of barriers and facilitators to uptake of HIV/SRHR services

Shifting Social Forces:

- How might we cultivate more supportive and open dialogue around HIV in the KP community?
- How might we create the conditions for KPs in their diversity to feel comfortable connecting with HIV services?
- How might we transform the social narrative and implications of living with HIV

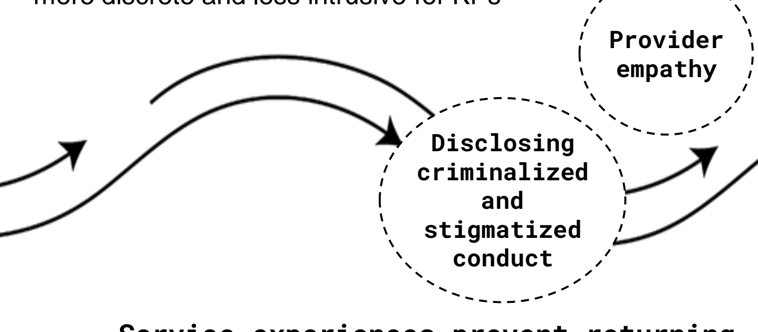
Creating a testing experience that affirms diverse KPs:

- How might the HIV testing experience feel private, trustworthy and seamless for KPs
- How might KPs see providers as empathetic, knowledgeable and supportive allies for their health issues?
- How might information exchanges for health services be more discrete and less intrusive for KPs

Risk of being exposed

Fear of social fallout

HIV Services



Social forces prevent access.

Combination Prevention Approach for Delivering Core Integrated HIV/SRHR Interventions for KP

Biomedical

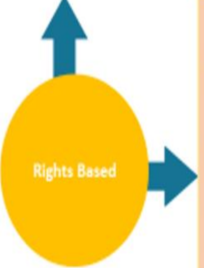
Interventions that use clinical and medical methods e.g.,

- Condoms and lubricants
- Antiretroviral treatment as prevention
- Pre-exposure prophylaxis
- Post-exposure prophylaxis
- Voluntary medical male circumcision
- Needle and syringe programmes

Structural

Interventions that promote an enabling environment e.g.,

- Decriminalising sex work, homosexuality and drug use
- Addressing gender inequality and violence
- Laws to protect the rights of people living with HIV and key populations
- Interventions to reduce stigma



Behavioural

Interventions that encourage safe behaviour e.g.,

- Risk reduction counselling
- Comprehensive sexuality education
- Peer education programmes
- Social marketing campaigns, e.g., to promote condoms

Condom and water based lubricant distribution	Differentiated HIV Prevention and Care Services	Pre-Exposure Prophylaxis (PrEP)
Post exposure prophylaxis (PEP)	VMMC	Modern contraception
Cervical cancer screening and treatment of preinvasive lesions	Screening, diagnosis, and testing for sexually transmitted infections (STIs),	First line support to survivors of gender based and or intimate partner violence (GBV/IPV)
Anti-retroviral therapy (ART)	Viral load monitoring	Enhanced adherence counselling
Advanced HIV Disease Management	Adherence support for virologic suppression	Harm reduction

Integrated Monitoring and Evaluation of KP program

DHIS2 platform/ EHR

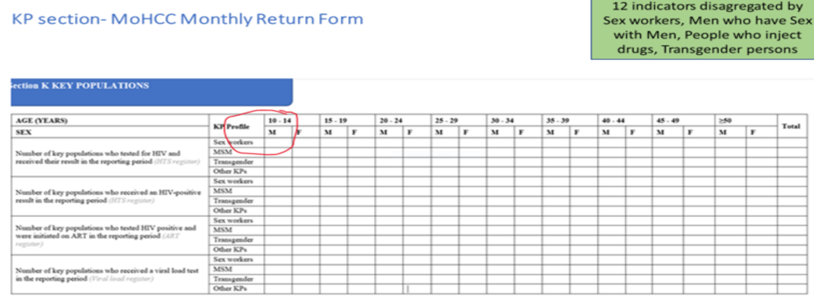
- KP data disaggregation
- HIV prevention and treatment cascades

Routine data collection for structural intervention

- Stigma index surveys
- Legal Impact Environmental Assessements

Community Led Monitoring

- Community led solutions
- Early warning mechanism for new and re-emerging challenges
- Quality improvement tool



KP section- MoHCC Monthly Return Form

12 indicators disaggregated by Sex workers, Men who have Sex with Men, People who inject drugs, Transgender persons

ection K KEY POPULATIONS

AGE (YEARS)	KP Profile	10 - 14		15 - 19		20 - 24		25 - 29		30 - 34		35 - 39		40 - 44		45 - 49		≥50		Total
SEX		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Number of key populations who tested for HIV and received their result in the reporting period (HTS register)	Sex workers																			
	MSM																			
	Transgender																			
	Other KPs																			
Number of key populations who received an HIV-positive result in the reporting period (HTS register)	Sex workers																			
	MSM																			
	Transgender																			
	Other KPs																			
Number of key populations who tested HIV positive and were initiated on ART in the reporting period (ART register)	Sex workers																			
	MSM																			
	Transgender																			
	Other KPs																			
Number of key populations who received a viral load test in the reporting period (Viral load register)	Sex workers																			
	MSM																			
	Transgender																			
	Other KPs																			

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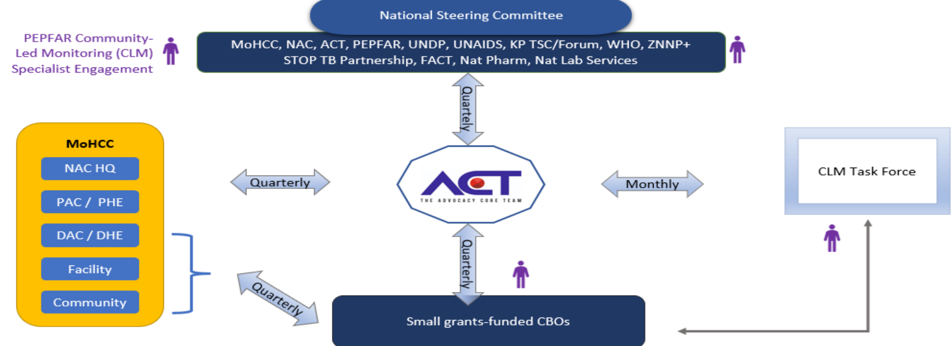
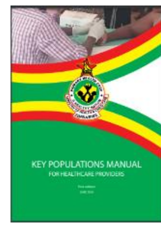
Community Led Monitoring Ecosystem



Progress integrating HIV Prevention and SRHR models for Key Populations

2018

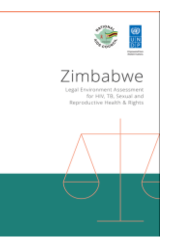
Training manual for service providers on key populations , including Job aids and a minimum service package for different KP subgroups



2019

Zimbabwe Legal and Environmental Impact Assessment for KPs,

UNDP, NAC

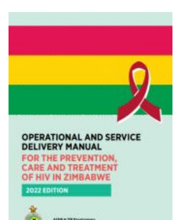


2020

Treatment and Rehabilitation Guidelines for Alcohol and Substance Use disorders

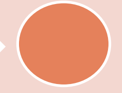
2022

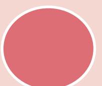
Operational Service Delivery Manual with special considerations for key populations



2023

Development of a KP Implementation Plan with Harm reduction for PWUID



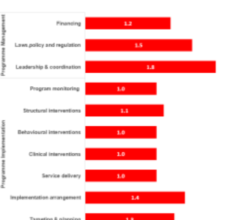


2020

Zimbabwe National Drug Master Plan

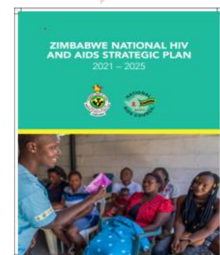
2022

Review of National HIV Prevention Program (PSAT Lite) for KPs including PWUID

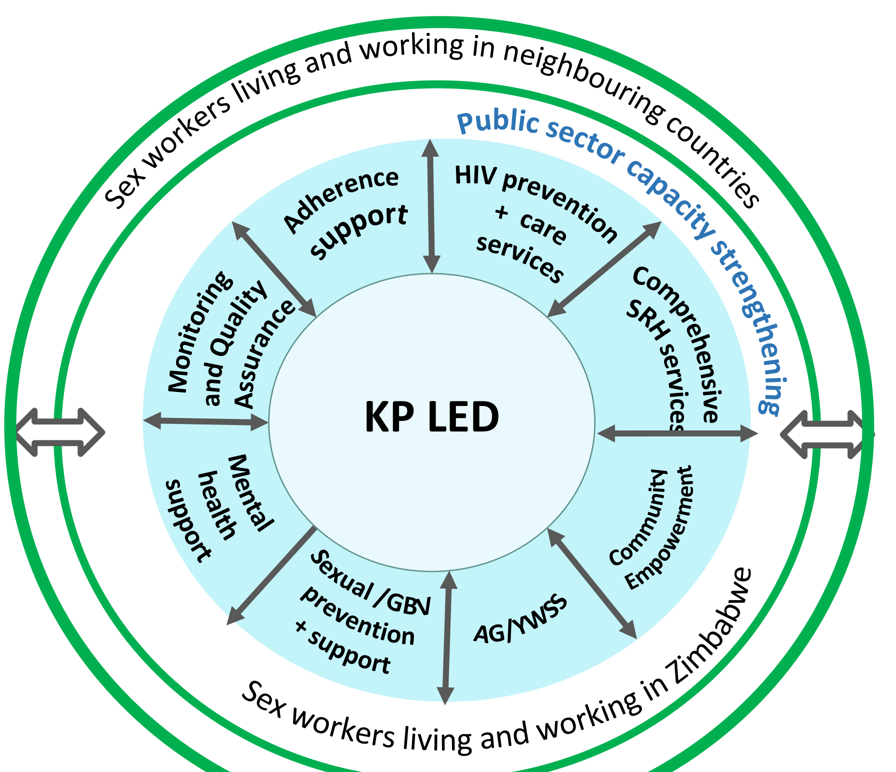


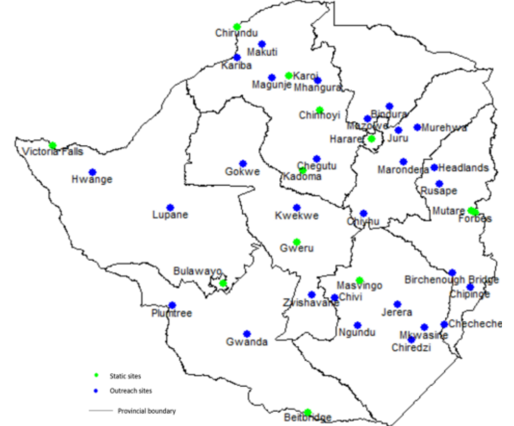
2023

Midterm review of ZNASP IV emphasizes establishment of HIV prevention and harm reduction interventions for PWUID



Integrated Sex work programme





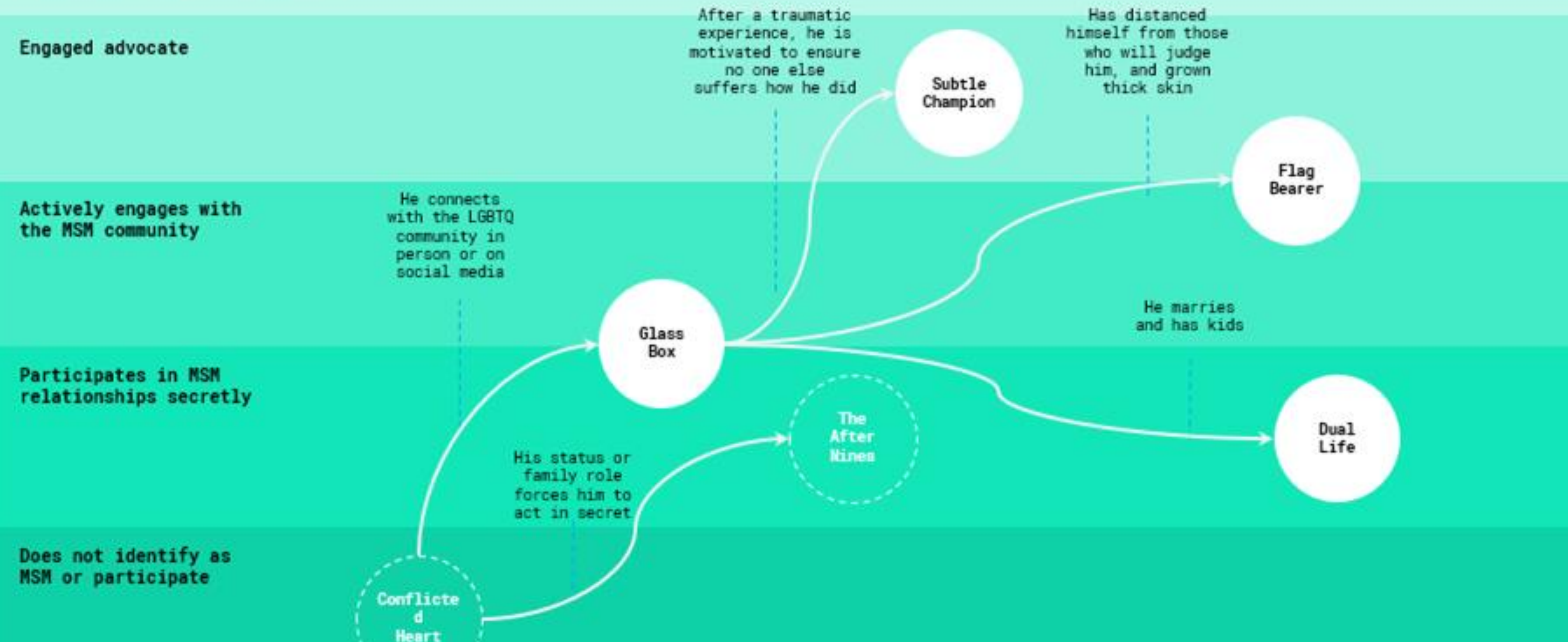
Target: All sex workers (female, male, transgender)

86 implementation sites with extensive community-based outreach and service provision;
Comprehensive services in one stop centre approach

- **12 static clinics** co-located in public sector sites in major cities/towns and at major borders
- **34 local mobile clinic sites** co-located in public sector sites in major cities
- **10 Drop-In Centres separate from public facilities** (6 specifically for YWSS -GiRLS Clubs)
- **30 highway mobile clinic sites** co-located in public sector sites

Human Centred Design Insights on MSM

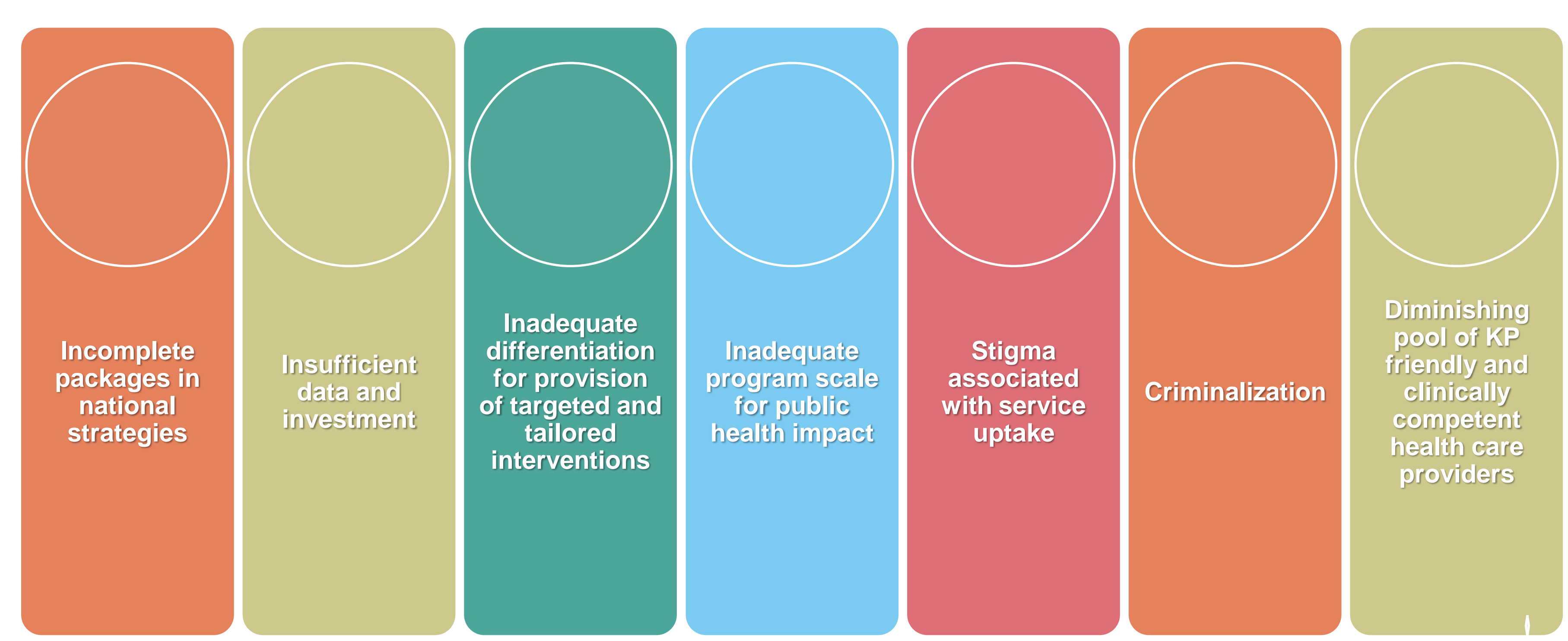
An MSM is never static. Over time, he may change and take different trajectories depending on his experiences and his corresponding mindsets and behaviors.



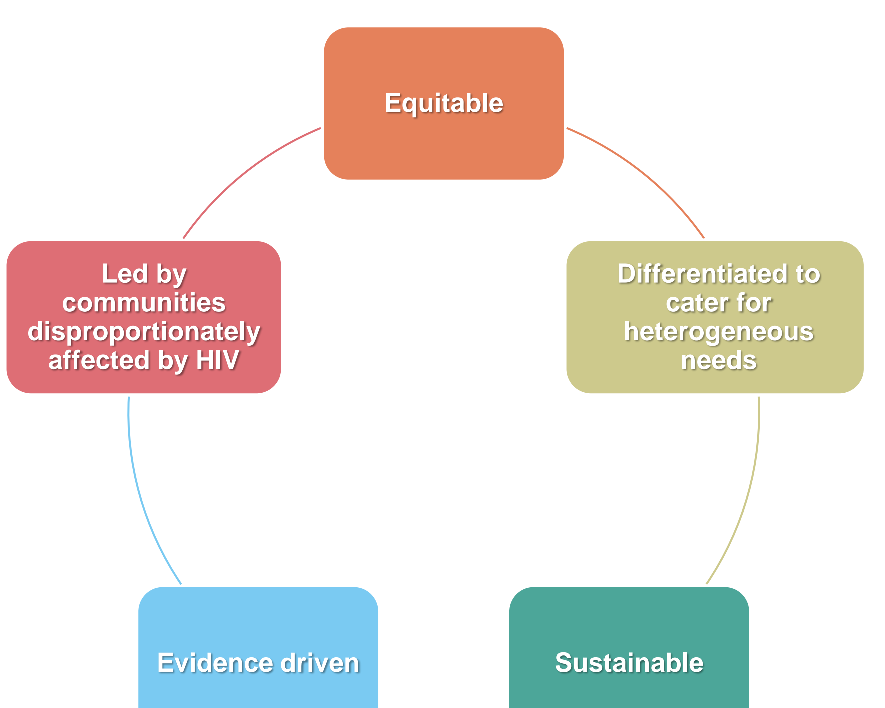
Service Flow

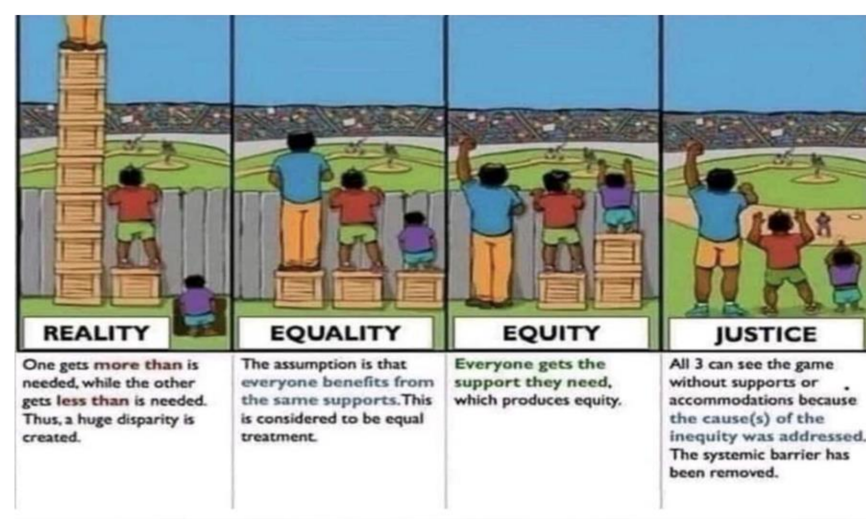
Within each moment, there are critical components that bring a client's experience to life. Ideally each client should experience the following touchpoints when visiting ColourZ

Barriers to implementing integrated HIV/SRHR intervention



Considerations for successful integration





"We shall strive to know and close the gaps."

Ambassador John Nkengasong, PEPFAR

Thank you

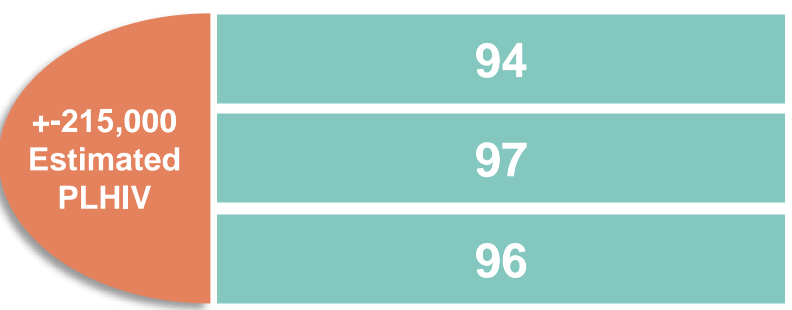
Humphrey M Ndondo | He/Him/ His

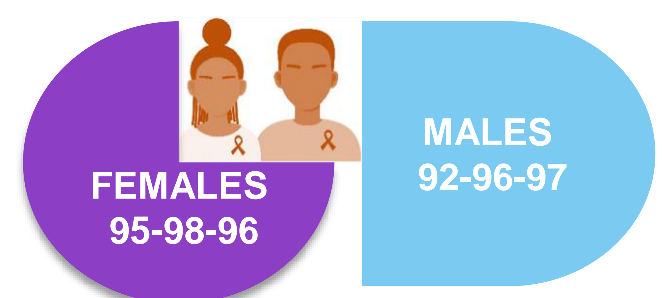
Senior Technical Specialist Key Populations: National AIDS Council

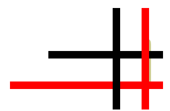
Service Delivery Models for Key Populations in Eswatini

Sindy Matse
Acting Program Manager
Eswatini National AIDS Programme

THE HIV EPIDEMIC IN ESWATINI







Epi review for KP in Eswatini

Population size estimates for target PP:

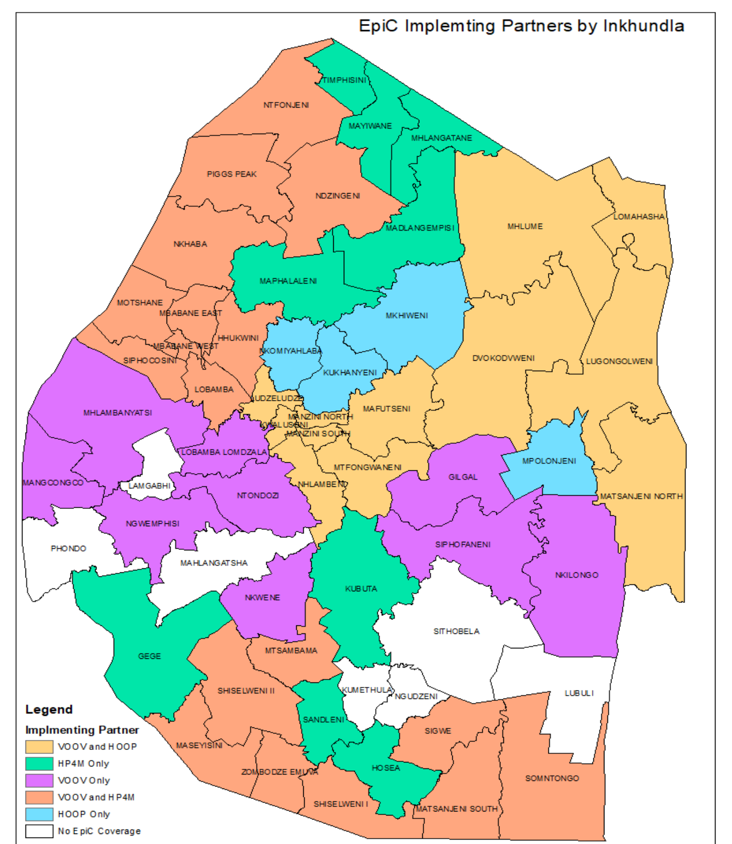
	2015 PSE
FSW	12 274
MSM	5 085

	2021 PSE	
	Median	Lower range range-higher
MSM	4000	3190-6574
FSW	7056	3400-14581

- **PWID:** 854 (2020 assessment)
- **TG: 105** TG (2021,Transwati assessment)

HIV Prevalence among KP:

	2011 IBBS	2021 IBBSS
FSW	**60.1%** (70.3% unweighted)	**58.8%** (68.8% unweighted)
MSM	**12.5%** (17.7% unweighted)	**21.0%** (28.8% unweighted)
TG	No data	**41.2%**
PWID	No data	18% Self reported



HIV care and treatment Cascade (95-95-95) for MSM and FSW combined

1st 95
88% those living with HIV knew their status

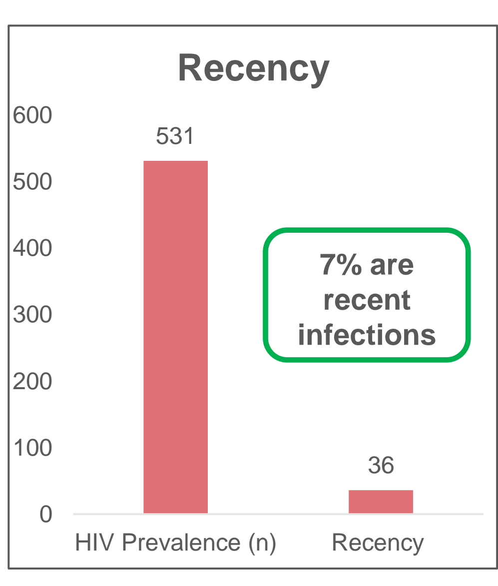
2nd 95
97% those who know their status and are on treatment

3rd 95
94% of those on treatment who are virally suppressed

600
500
400
300
200
100
0

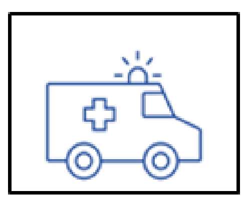
531
425
411
385

HIV Prevalence
Known HIV+
Curently on ART
Virally Suppressed



DSD Models in Eswatini

- Outreach clinics: services are provided through traditional outreach at hot spots for Key populations (KPs)
- Drop-in centers: combination of services and safe space for KPs
- Hybrid: facilities where service provision largely depends on other stakeholders, such as in public and private health facilities



Major DSD Service Provision Platforms among KP

KP Community Centre

ORWs

KP Community Centre:

- 2 KP Centres
- Established in 1 October 2019
- Community Ownership
- Operates 3 days in a week for clinical services
- Services provided directly by KP Organisation with Technical support from FHI 360
- FHI360 provides technical oversight
- Targets KP: MSM, Trans, FSW, PWID
- Clients either book online or through ORWs mobilization
    - www.trueeswatini.com is used for ORA online booking.

Mobile Clinic Outreach:

- Covering: four regions
- Target: MSM, FSW, PWID and trans
- Services provided by FHI 360 mobile clinic and KP partners create demand

Mobile Clinic

ORWs

Service packages for the different models

DIC SERVICE PACKAGE

- HTS- including Recency and Index Testing
- PrEP initiation and refill
- PEP initiation
- ART initiation and refill
- Viral Load Testing
- Treatment of Minor Ailments
- PSS care
  - GBV Case Management
  - Adherence management
- Family Planning
- STI screening and treatment
- TB Preventive Therapy
- Cervical Cancer Screening: VIA
- Commodity Distribution
- Covid- 19 Vaccinations

- Safe Spaces
- Resource centre
- Internet hot spot access
- Abscess prevention commodity distribution
- Empowerment sessions
  - HIV Prevention Group Discussions
  - Sensitization meetings
  - PSS Group Discussions
  - Cell Groups

OUTREACH SERVICE PACKAGE

- HTS- including Recency and Index Testing
- PrEP initiation and refill
- PEP initiation
- ART initiation and refill
- Viral Load Testing
- Treatment of Minor Ailments
- PSS care
- Family Planning
- STI screening and treatment
- TB Preventive Therapy
- Cervical Cancer Screening: VIA
- Commodity Distribution

Overview of DSD Interventions along the HIV Treatment Cascade

HIV Testing for Case Finding

- Home-based HIV testing provided to KP.
- Mobile clinic outreach HIV testing at community-level hotspots.
- KP drop-in-centres based HIV testing at 2 KP Community Centres in major cities.

ART Drugs Delivery

- Mobile clinics ART initiation at community-level hotspots for KP
- Provide home-based ART initiation and refills
- Provide ART initiation and refills at 2 KP Community Centres
- Provide community-based support for adherence and retention to ART through peer navigation and psychosocial services.

VL Collection and Monitoring

- Home-based sample collection with lab drops (DBS specimens).
- Mobile clinic outreach DBS specimen collection at community-level hotspots.
- Virtual enhanced adherence counseling for clients with high viral load.

DSD Platforms/Modalities

Modality	Definition
Mobile outreach	Community mobile outreach clinics providing services to KP in the communities where they live or socialize. Clients normally tested with rapid test.
Moonlight/Makeshift Venue-Based Clinics	Temporary rented rooms/venue/structure where services are provided in any relevant location (e.g. bars, brothels, safe spaces)
Home-based HTS	Houses for MSM/TG or any other safe spaces where MSM/TG convene or socialize.
One-on-One (Appointment Based)	One-on-one service provision at chosen locations. This can occur at home/work or a neutral and safe location
KP Community Centres	TRUE Community Centres which operate on certain days of the week.
KP community events	The KP community supports larger events where peers and support networks come together to support different key issues identified by the community.

Results from DSD models

DSD models improved access and adherence to treatment among KP

	Issue	DSD implemented	Period of results	Change / Improvement
PrEP initiations	There was very low PrEP continuity.	DDD	Nov 2022 - March 2023	6% (59/931) - 75% (699/931)
Linkage to ART Treatment	Low ART initiation as DSD models were limited.	DDD	Nov 2020 – Dec 2022	67% - 92%
Viral load coverage	Low VL coverage as it was only collected in facilities.	DDD	Nov 2021 – March 2023	21% - 99%

Pros and Cons for Different DSD Models

Community Centres

Pros:

- They are one-stop shops with comprehensive services under one roof.
- Clients have a static site where they come back for follow-ups refills at any point.
- Higher retention as clients can always come back for refills.
- Provides more than clinical services – also non-clinical social services.
- Mobilization include going online and clients can make appointments through online reservation app (ORA).

Cons:

- Currently not operating as full-fledged clinic – opened on specific days
- They are located in 2 cities and only serve their catchment areas.

Mobile Outreach

Pros

- They are flexible and provide services where the people are at their convenient time.
- Has maximum coverage as it covers hotspots in all 4 regions of Eswatini.
- Services are not paid for directly by clients.
- Services provided by diverse teams, including service providers and community peer navigators / community outreach workers.
- Addresses inequalities in services access and treatment outcomes – especially among those not having resources to access services elsewhere.

Cons

- Some services cannot be provided if they need more privacy and advanced set-up e.g VIA was stopped at some point as gazebos used were not providing needed privacy.
- Social and environmental conditions may affect service delivery, e.g. weather conditions and recently political unrests restricted movements to deliver services.

Hybrid (Public/Private Facilities

Pros

- Clients can access services to facilities closer to them
- There is no limitation of days of service provision (during the week) as they are static sites.

Cons

- They are closed at certain time of the day and some on weekends
- Services are paid for, with minimal fees in public facilities and high charges in private.
- There is general perceived unfriendly services or stigma.
- Services are generic to all clients and not tailored to specific populations

Impact from DSD models

- Provision of HTS at KP hotspots enhanced access to HIV prevention and treatment services.
- Increased ART initiation and linkages to treatment among KPs.
- Establishment of drop-in centers for KP and provision of CCD/DDD services have contributed to increased number of KPs on treatment since KPs prefer receiving their treatment from the DIC or CCD compared to public facilities.
- Through provision of DSD services KP Viral load suppression rate is currently 99%. This has been enhanced by the sample collection at community level which addressed the barriers of transport and affordability.
- DSD improved ART retention among KP living with HIV
- Increased access to integrated services i.e. TPT, cervical cancer screening, SRH services and psycho-social support for those requiring counselling sessions.

Challenges

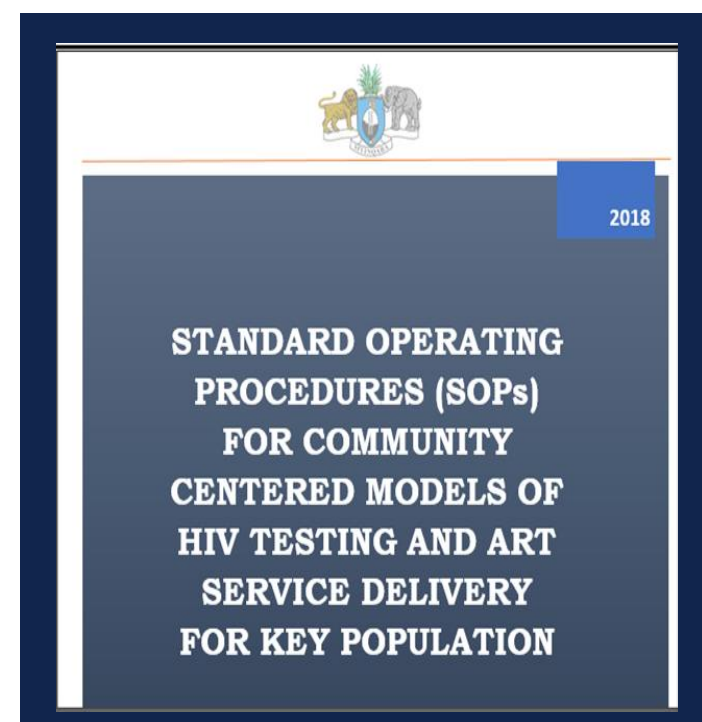
- Highly mobile clients such as FSW who skip appointment dates due to travel outside their normal place of residence.
- New emerging KP hotspots that the implementing personnel is not aware of.
- Transport operators not able to pick their medications (ART, PrEP) due to their nature of where they are always busy through the day.
- Some clients are found in hotspots intoxicated during service delivery which makes it hard to provide clinical services.
- Clients referred to public facilities for other services like TB investigations, further investigation and management of VIA positive FSW delay accessing services.

Learnings from DSD Models

- Targeted services
- Improved quality of services delivered to KPs
- Community-level care
- Decentralized health care services
- Services are brought closer to the beneficiaries
- Improved client satisfaction
- Use of diverse health care teams and peer support makes services tailor-made
- Individualized care
- It promotes differentiated services, as Patients receive tailored packages of HIV services
- DSD helps address inequalities in treatment access
- Better engagement of the KP community
- Where there are structural barriers to access services among KP, e.g. fear of stigma/discrimination, lack of resources to reach facilities, DSD models provides services in a stigma free and private space

Enabling Factors for DSD

- SOP was developed by MOH in 2018 to guide DSD models
- Coordination of the KP program implementation through the KP TWG
- Standardized implementation through MOH guidance on job aids, manuals and IEC material development
- Standardized training of KP implementing partners and health care providers



Discussion
and
Q & A

Key takeaways

From **South Africa**

and

Ghana

THANK YOU